Nursing Homes

OFFICIAL JOURNAL - AMERICAN NURSING HOME ASSOCIATION

In this issue:

Cleveland, Ohio
Convention City - A.N.H.A.
October 2-6, 1961 - Pick Carter Hotel

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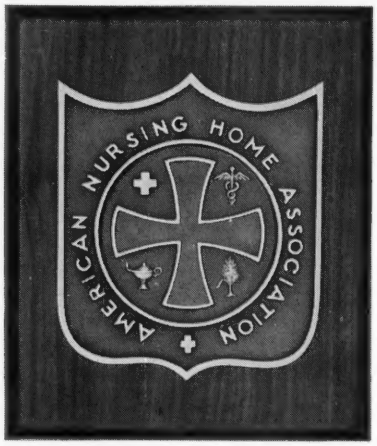

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Busy Cleveland -
YOUR CONVENTION CITY

This is the story about Cleveland, your convention city.

This is the story about the host city and what it offers you, its guests, when you attend the forthcoming meeting there.

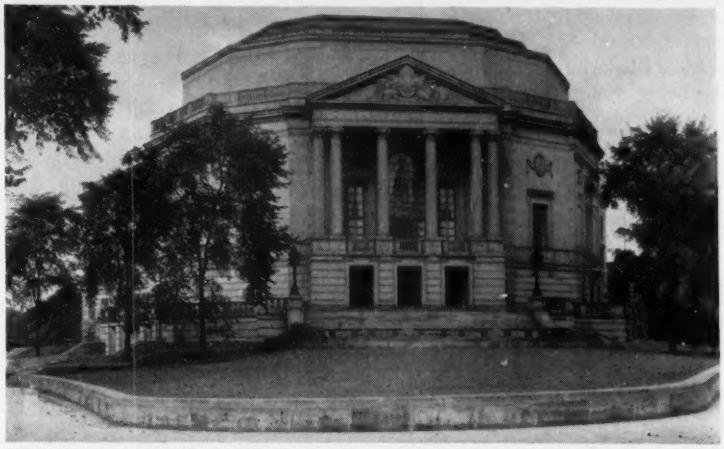
It is a prospective conventioneer's size-up of the town.

The Cleveland of today is a big, busy city — Ohio's first and the nation's seventh. It is nothing like the spot along Lake Erie and the Cuyahoga River that General Moses Cleveland surveyed in July, 1796. This spot now is a city of more than a million people, the capital of a great trade empire, and an industrial giant ranking with the greatest in the world.

Offers attractions

The Cleveland of today also offers all the attractions of a great metropolis befitting its size and prestige. The cultural and educational institutions, the parks, and the entertainment facilities of Cleveland are among the finest in the world. The beautiful shores of Lake Erie, both east and west of the city, offer a great variety of attractions. And the entire area surrounding the great city is one of beauty and interest.

As a place to gather, Cleveland offers many attractions and points of interest. It is perhaps more noted as a cosmopolitan community than any similar metropolis its size because of its heterogenous population. The city, whose metropolitan area and overnight rail time of the city. stretches out from the Lake Erie shoreline like a fan, is particularly known for its fine cultural institutions and civic spirit and in 1946 celebrated its sesquicentennial. Largely industrial in character with emphasis on steel and parts manufacturing, Cleveland is "the best location in the nation." The term is a simple statement of a superlative fact — describing the industrial advantages of the Cleveland area's location in the market center of America.



SEVERENCE HALL, Cleveland, Ohio, home of the world-famed Cleveland Symphony Orchestra . . . This acoustically-perfect building is located in the University Circle on the east side of Cleveland.

ART MUSEUM and lagoons, Cleveland, Ohio . . . This building also is in the University Circle area — the cultural center of Cleveland.

Cleveland's central location assures a good attendance for conventions and one which is easily accessible to a majority of delegates. Half of the population of the United States is within a 500-mile radius Convenient, fast, and modern transportation facilities of all kinds are available in and out of the city.

Has compact layout

Cleveland's compact layout is another convention advantage. All major hotels, the shopping district, transportation points, amusements, Lake Erie, and the Public Auditorium are all within a few minutes walking distance. Any point in the city is easily accessible from the downtown area.

At the hub of the city's business activities in the Public Square, a small clearing of land which was purchased by the Connecticut Land Company in 1795 for $1.76 and which is now a modern business and transportation center valued at more than $20,000,000.00. Towering over the square is Cleveland's familiar landmark, the 52-story Terminal Tower, with an observation room on the 42nd floor that affords a splendid view of the city. It is the seventh tallest building in the world, the other six being in New York. Other parts of the Terminal unit are a

railroad station, a large department store, a modern hotel and several shops.

Building attractions such as this aren't confirmed to the Public Square, however. Many huge office and civic buildings dot the Cleveland scene and have attracted the attention of the whole nation. The Mall, for example, is one of the most ambitious undertakings ever attempted. This plan of grouping public buildings around a spacious seventeen-acre downtown garden spot represents an investment of more than $40,000,000.00. The Mall, which overlooks Lake Erie and extends into the heart of the business district, is made up of seven great buildings. America's best equipped convention plant – the $10,000,000 Public Auditorium; the Federal Building; the Public Library; the new Board of Education Building; City Hall, Cuyahoga County Court House, and the lakefront Municipal Stadium seating 83,000, are included in the Mall Development.

Nation's finest auditorium

Famed throughout the country for its unique facilities and capacity, the auditorium has housed many of the largest meetings and expositions that are annually held in the United States. It is considered to be America's finest and most serviceable municipal auditorium.

The Hall has three theatres, ten halls seating 75 to 500 each and many committee rooms and offices which make it ideal for an all-around convention operation. The main auditorium seats 12,500; the Music Hall seats 3,000 and can be thrown together with the main hall so that 16,000 can watch the action on the 5,000 square foot stage.

Cleveland also ranks among the nation's outstanding cultural and educational centers. Western Reserve University, comprising various colleges, is one of Ohio's oldest and best collegiate institutions. Case Institute of Technology, adjoining the campus of Western Reserve, is among the country's top engineering schools. The two institutions occupy high ground overlooking beautiful Wade Park. Other Cleveland collegiate institutions are John Carroll University and Fenn, Ursuline and Notre Dame Colleges.

Cultural Center

Gems of the city's cultural treasures are the Cleveland Museum of Art and Severance Hall, both located in University Circle overlooking Wade Park on Cleveland's east side. The art institution is one of the most beautiful museum buildings in America and through its cooperation with the city's schools and colleges has become an essential factor in the educational life of Cleveland. Severance Hall is the $2,500,000 home of the Cleveland Symphony Orchestra and has done much to carry the story of Cleveland's education and cultural progress to the rest of the world. Other famous institutions in Cleveland include the Museum of Natural History, the Western Reserve Historical Society Museum, Dunham Tavera, the Public Library, the Health Museum, Brookside Zoo, Nela Park University of Light, and Cleveland Airport.

In addition to visits to Cleveland's many noted landmarks, there is a great variety of recreation and entertainment pleasures in store for the city's guests. Outdoor lovers can get their fill in the community's park system, swimming in Lake Erie, golf, tennis, American League baseball, horse racing, boating and numerous summer resorts.

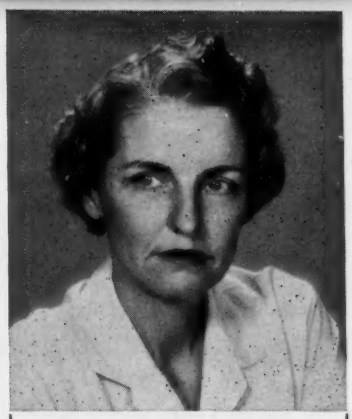
Fall and winter season sporting attractions include professional and collegiate football, basketball, hockey, boxing and wrestling events.

Cleveland's show houses present the cream of the nation's theatrical talent. In playhouse Square, with its 12,000 seating capacity, theatres not only offer excellent productions, but they also are attractions in themselves.

With Cleveland in an especially fine mood to welcome its guests and with the city's traditionally kind and friendly spirits as a convention host in the offing, visitors attending this convention are in for a memorable experience.

Supplying the Nutritional Needs of Older Persons

By MRS. MARIELLA W. SMITH
Nutrition Consultant,
Division of Services for the Aging
State Dept. of Social Welfare
Topeka, Kansas



Mrs. Mariella Smith holds an A.B. degree in home economics from Washburn University, Topeka, Kansas; has taught home economics; is presently chairman of the Kansas Home Demonstration Council; and is active in the Topeka Home Economics Association.

I am really concerned about the lack of interest so many of our older people seem to have in food, especially what is really good for them. Some people feel that food problems are concerned only with youth. When we talk about youth, it is rather silly to measure age in years, since many people in their eighties and nineties are young because they are interested in others. They keep busy, eat properly, and stick firmly to a cheerful outlook toward the little joys of life.

No Isolation

Nutrition should not be considered apart from all the other environmental factors which affect health. We must not isolate the aging person and we must not isolate nutrition when considering his health problems. The older person is still a human being with the same needs, wants and desires of most of us humans.

Unfortunately our present day senior citizens went through their growth period about fifty years ago when very little was known about the science of nutrition. Many of them have never made an ally of food — good food, that is, that will help them in many ways. Many of them, over the years, have developed eating habits which cause much concern to those of us working to improve their diets. Mark Twain once said: "Habit is habit, and not to be flung out of the window by any man, but coaxed downstairs a step at a time." The older we become, the more fixed are our habits; and habits, whether good or bad, last longer than life itself.

The basic needs for good nutrition in the aged differ little from those of younger adults, although various physiological changes occur with the passing years that call for some modification of the diet. These physiological changes cause:

(1) A reduction in the body's energy requirements.

(2) A decrease in the quality of digestive juices secreted.

(3) A slower response to food by the digestive tract.

(4) The loss or impairment of the teeth.

Both old and young are equally affected by severely deficient diets, and both show good recuperative powers when adequate diets are ingested. Whether an individual arrives at old age malnourished or well nourished is largely a matter of his own choice. What he chooses to eat, how much or how little, and the environment in which he eats it, may be a powerful determinant in whether he ever reaches 65, 75, or 85. And, if he merely exists at age 85 or if he is alert, vigorous "for his age," interested in life about him, and is a delight rather than a burden to himself, his family, and his community . . . all of this depends heavily upon the day-by-day flow of essential nutrients to every cell in his body as long as he lives. It is difficult to get accurate requirements for this age level because individual variation, which is always wide at any age, increases with age. Research is being carried on to determine what the requirements should be for this age group.

Nourishment

We do know that being badly nourished is often the reason for complaints that drag down an older person. It may cause such complaints as a chronic tired feeling, a gloomy outlook on life, anxiety over small things, loss of sleep, and yes, even too much weight. A well nourished body responds better to treatment than one in a run-down condition.

When we think about what constitutes an adequate diet, we think in terms of what basic food groups must be included each day to supply the nutrients essential for good nutrition.

Milk or milk products must be included each day. We need milk mainly for the calcium it supplies. Calcium is needed at every age for upkeep of the bones and normal functioning of the nerves and muscles, including the action of the heart. Milk is also a good source of protein, and vitamins — especially riboflavin and Vitamin A.

Proteins and Minerals

We need protein and minerals which are required for the upkeep of the body tissue and bone. Listlessness, fatigue and lack of vigor and zest result from a diet which supplies insufficient protein for the daily upkeep. You are more likely to overeat when your diet scores low in protein and is poor in other qualities, than when it is nutritionally good. The older person needs two or more servings a day from the meat group. Meat, fish, poultry or eggs and cheese can supply the protein needed each day. You can use nuts, dry beans, and peanut butter as part of the protein requirement. However, all vegetable protein must be supplemented with an animal protein.

Vegetables and fruits are needed each day to supply the vitamins, minerals and roughage needed for good nutrition. Four or more servings are needed daily from this food group. From this group we get most of our recommended Vitamin A and all of our Vitamin C. Vitamin C can not be stored in the body and therefore must be included in each day's planning. Vitamin C is essential to help resist infection and help in healing.

The aged also need four or more servings a day from the bread and cereal group. Foods in this group supply valuable amounts of protein, iron, several B Vitamins and food energy.

Need Additional Foods

They also need additional foods for fuel, for energy and warmth. We can choose additional foods from the four food groups to help us achieve an adequate diet and meet these energy needs. We must be careful not to serve too many high calorie foods that have little nutritional value, as most of our older people are not very active and do not need lots of calories in a day. I do not want to imply that you should count every resident's calories, but just think about the high calorie foods, when you are planning your menus, and do not include them too often. I know people like pie and cake, but these should be served only occasionally as a special treat and not as a daily diet. Of course, when the doctor orders a special low calorie diet, diabetic diet, low sodium diet, etc., the instructions should be followed. For most of our residents, we want them to have good well-balanced diets with a wide variety of foods. They do not need hospital diets just because they are old.

I would like to say a little at this time about what we mean when we say a serving of a certain food. To meet requirements we must serve foods in the quantity required. Adequate serving of meat should be at least three ounces, cooked. When we speak of a serving of vegetables or fruit, it is at least one-half cup. It may be more. Bread and cereals are one slice of bread as a serving and one-half to three-fourths of a cup of cereal denotes a serving. Milk or its equivalents should be a minimum of two cups per day to meet requirements.

Some of the common food deficiencies, we find in the older person, are calcium, iron, Vitamin C and other vitamins. Two prevalent ideas about food may be partially responsible for this, namely, that milk is a food intended for children and that acid containing foods will produce a condition of acidity in the body. Since milk is a very rich source of calcium and riboflavin and citrus fruits and tomatoes are among the best sources of Vitamin C, people who don't include these in their diets will be low on these nutrients. Milk is an excellent food for adults, as well as for children. It contains most of the nutrients needed by the adult body and it is readily digested and tolerated by most people of all ages. The concept about acid containing fruits is equally false because the organic acids which they contain (chiefly citric and malic) are readily oxidized in the body. These foods are excellent "alkalizers," because they contain generous amounts of the alkaline minerals which help to neutralize the acids which are formed by the acid-forming minerals contained in the meat, fish, eggs and cereals of the usual diet. The acid containing fruits may be better "alkalizers" for the older person to use than soda bicarbonate. The natural acidity of the gastric juice tends to decrease with advancing years and taking soda decreases it even further. This then may interfere with normal digestion of protein and the absorption of calcium and iron. Also, the body utilizes most nutrients more efficiently when moderate amounts of them are being absorbed. Especially for the aged person, meals should not be overloaded with a single type of food.

Sources of Vitamin C

Good sources of Vitamin C are the citrus fruits — oranges, grapefruit, lemons, limes, also strawberries, cantaloupe, tomatoes, green peppers, raw cabbage and broccoli.

Good sources of iron are lean meats, especially liver, eggs, dried fruits, (such as, apricots, peaches, raisins, prunes, and dates), spinach and greens, and dried peas and beans.

When we think of what we mean by good food service, we must think of menu planning, food preparation and the method of serving the food. Menu planning in advance is important, both from the standpoint of saving time and money. When the weekly meal plan is made out, we know what and how much food to buy. We can also avoid frequent repetition of certain foods that make meals monotonous, and can check on color and texture of foods in the same meal. We also are better able to see that we have an adequate diet, which includes all the basic food groups and total servings as required.

Food preparation is of great importance because if food is not prepared to conserve the nutrients in the food and is not seasoned properly, the older person will not get what he should have. Many of the minerals and vitamins are lost from our vegetables by cooking them in too much water, over cooking them and then pouring the water down the drain. High heat causes loss in food values. Seasoning is of great importance in cooking for older people. As we get older our sense of taste is apt to decrease and we do not realize that it is the lack of seasoning that makes the food taste wrong.

Stresses Special Diet

I would like to stress here that special diet foods should be cooked separately. Lots of cooks say they "just fix" the food for everyone and take out food for a special low sodium diet and then add salt to the rest or let the residents add their own salt. This I feel is wrong, because most foods just naturally taste better when seasoned during cooking.

Also, in regard to the preparation of the food, we should find some time to visit with each resident to find out his likes and dislikes, and his problems in eating. Often the resident, free to voice his opinion in regard to his diet, finds that he is satisfied and contented with the regular fare. Taking the time to visit about food shows the resident that you care about him and this takes away some of the feeling of lonesomeness and being rejected. We can often find that a person prefers his egg poached to scrambled, or that

(Con't. on page 18)

Nursing Homes

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IN THIS ISSUE

COVER PICTURE:

Beautiful skyline of Cleveland, Ohio — a city of cultural, educational, medical, and progressive business institutions. You will enjoy your visit to this city and long remember it.

EDITORIAL OFFICE:
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Montanans Plan to Improve Patient Care

Report by G. D. CARLYLE THOMPSON, M.D.
Executive Officer and Secretary of the
Montana State Board of Health

In December 1960, the Montana State Board of Health sponsored a two-day Conference in Helena, Montana, at which more than a hundred citizens discussed the problems involving the improvement of patient care in Nursing Homes. Montana, like the rest of the nation, is concerned with the need for more nursing homes—and for the improvement of patient care in those which exist.

In opening this Conference, G. D. Carlyle Thompson, M.D., executive officer of the State Board of Health, stated that several developments in the State had brought about this Conference. These were: (1) the 1959 revised State Board of Health Rules and Regulations and Standards pertaining to nursing homes under the hospital law and to nursing and/or boarding homes for the aged; (2) the exploration and the start of a program in Gallatin County between the city-county health department and the nursing homes in that area; (3) proposals and interest of the Montana State Nursing Home Association, particularly during the past year; (4) the adoption by the State Board of Health of a program to improve patient care in nursing homes through the use of special funds appropriated by the last Congress at the request of the President for this purpose; (5) the obvious need for nursing home facilities in Montana and a substantial interest in many communities in providing such facilities.

Representation at the Conference

Invitations were extended to State groups who are concerned with nursing homes. They were: State Department of Public Welfare, Montana Nursing Home Association and other Nursing Home operators, State Bureau of Vocational Rehabilitation, Advisory Hospital Council to the State Board of Health, County Commissioners Association, Veterans Administration Hospital, State Fire Marshal, Montana Medical, Dental, Hospital, Pharmaceutical, Dietetic and Nursing Associations, Montana State (Mental) Hospital, the Governor's Committee on Aging, the Montana League for Nursing, the Public Health Physicians Association and the Unemployment Compensation Commission.

Conference Preplanning

Mary E. Soules, M. D., Disease Control Director of the State Board of Health is the chairman of the Board's staff committee. This committee also has representation from the Board's divisions of Hospital Facilities, Public Health Education, Child Health Services, Public Health Nursing and Environmental Sanitation. To this staff the executive officer assigned the planning and management of the Conference.

Several agencies were asked to name a representative to a planning committee to assist the Board's staff in planning the conference. They were: Montana Medical Association, Montana Nurses Association, State Department of Public Welfare, Montana State Nursing Home Association, Montana Hospital Association and Montana State (Mental) Hospital.

Conference Purpose

Dr. Thompson stated the purpose of the conference was not only to consider the physical facilities that are needed, and this need is great. But that consideration was needed on how the existing facilities can be more effectively used under an appropriate plan for payment for services to assure proper standards for individual patient care. Furthermore, many community resources exist in Montana which could be brought to bear or could be developed to meet patient needs. Coordination of the services of many persons and agencies is indicated. To the extent that this is done and how . . . was the major problem for the conference participants.

The stage for the conference was set by a paper prepared by Bruce Underwood, M.D., Chief, Nursing Home Service Section, Division of Special Health Services, U. S. Public Health Service, Washington, D. C. The title of this paper was: NURSING HOMES; General Consideration. Dr. Underwood's paper was read by Mrs. Frances Wolford, Chief Nurse on Dr. Underwood's staff. She also presented comments from her viewpoint and served as a resource person during the conference.

Participants Went to Work

A review of the present situation of the Nursing Home and Personal Care Homes in Montana was presented in a symposium. Speakers were a practicing physician, a nurse, a welfare director — county commissioner, a nursing home administrator and a public health physician.

Problems that needed to be worked on in improving patient care were listed by the group as a whole. These fell into three categories: Financing, Administration and Services. The participants were divided into three groups each being assigned the problems in one of these major areas. The first afternoon and two hours of the second morning were devoted to these group discussions. The problems were explored, ways and means for solving the problems were talked about and suggestions made to help solve them. A few recommendations were adopted as starting points to meet the needs of Montana in improving patient care in this state. These recommendations were presented to the conference as a whole.

(1) It was recommended that *the State Board of Health licensing standards and their enforcement be continued with no change, and that those homes already established, but not meeting the standards, be given time to meet some of the more difficult ones.*

In these revised standards, Dr.

Thompson stated that nursing homes, personal care and boarding homes are defined. Thus, by classifying the homes on this basis, the confusion which has existed as to "what constitutes a nursing home" should be clarified. He stated further that a license issued for nursing home care covers the acceptance of patients in the personal care and boarding home classifications as well. However, licenses issued for boarding care are restricted to that category. The requirements for nursing home licensure require that skilled nursing care be provided.

(2) It was recommended that the Montana Medical Association's Executive Committee, in cooperation with the agencies and groups involved in medical care of patients in nursing homes, be asked to help resolve the problem of getting complete coverage of medical care for all nursing home patients. It was also suggested that the nursing home operators meet with the local Dental Societies to plan for the patient's dental care.

James A. Shown, M.D., Great Falls, Chairman of the Montana Medical Association's Committee on Aging, stated that increased physician services are needed. "Each patient should have a physical examination before entering a nursing home and at least minimal attention — routinely — after that; to say nothing of care during illness. Dental help is also necessary.

(3) Considerable concern was shown on the need for improved patient records. A plan for the exchange of pertinent information between nursing home, hospital, physician and family was suggested. Better communication was also recommended between nursing home and welfare department when the patient was a welfare client.

(4) It was recommended that fee schedules be based on (a) cost accounting, and (b) the types of facilities and services offered. It was further recommended that this be the basis of negotiating contracts for the care of indigent patients.

(5) The recommendations concluded with one which asked that the State Board of Health call another conference at some appropriate time to further discuss the many problems that will exist in caring for the chronically ill in Montana.

Responsibility

In the paper prepared by Dr. Underwood about nursing home problems and presented at the opening of the conference, he asked a dozen or two questions that are of concern to those in the nation and must be answered in each locality. Most of them were also Montana's problems. Dr. Shown stated, "Our problem is about the same as it is nationally. It remains, however, *our* problem." And in his conclusion stated, "It boils down to the fact that we must base all our studies on the need of the individual patient, with respect for his total personality and his basic dignity as a human being — about what we would like to have done with and for us if we are ever in need of such facilities."

Plan For Training Nursing Home Administrators Started

The California State Department of Public Health has contracted with the Attending Staff Association of the Rancho Los Amigos Hospital in Los Angeles for the development of a training course for owners and administrators of nursing homes, sanitariums, rest homes, and homes for the aged. The $50,000 project is being supported by funds from the USPHS 1961 General Health Grant, and is one of several activities by which California proposes to improve patient care and related services in nursing homes.

Private Physicians

The Attending Staff Association is an organization of private physicians who contribute their services to the Rancho Los Amigos Hospital. These physicians are largely responsible for the comprehensive rehabilitation services currently provided by this hospital, and they have much to contribute to the training program out of their experience with long-term rehabilitation programs.

The development of the training program will be under the direction of two men widely experienced in the fields of education, administration, and management. John Gerletti, Ed.D., Professor of Public Administration, on sabbatical leave from the University of Southern California, and C. C. Crawford, Ph.D., retired Professor of Education, U.S.C., will be responsible for the organization, administration, and evaluation of the project.

Objectives

The purpose of the project is to develop a sound training program in nursing home administration and management, which can then be adopted by a university, college, or other agency. The specific objectives include the following:

(1) To develop a formal training plan for nursing home administrators, including curriculum and training materials.
(2) To determine scope of acceptable services in nursing homes.
(3) To assess needs and problems of nursing home management.
(4) To evaluate training methods and materials.

The training program plan will be formulated after extensive study, assessment of needs, visits to nursing homes, conferences with nursing home administrators and other personnel, and contacts with interested persons in related fields. Professional persons skilled and experienced in organization and management techniques will be employed to formulate the plan. Teaching material, including bibliographies, manuals, guides and visual aids, will be developed. Experts in the specific areas will be recruited for participation in a pilot course which will be conducted in April 1961.

Following the two-week pilot course there will be an extensive evaluation of materials, course content, administration, and methodology, and any necessary changes will then be made before any material is published.

It is anticipated that the course will include basic information in such

(Con't. on page 10)

Nursing Home Institute — under the auspices of the Virginia Association of Nursing Homes, will be held at the University of Virginia, Charlottesville, Va., on July 18-20, 1961. Registration fee will be $20.00 for members and $30.00 for non-members. This fee will cover two nights' lodging, a banquet, and a certificate of attendance. All readers of "Nursing Homes" are invited to attend.

Bernard Maslan — president of the Virginia Association of Nursing Homes, has been appointed by the Medical College of Virginia to the position of Instructor in Hospital Administration. Mr. Maslan has suggested that in those areas in which universities and colleges have Hospital Administration Schools, that nursing home administrators who have the talent and time seek the establishment of Nursing Home Administration Courses — offering their services as a consultant or on a full-time basis. Such achievement would be the means of creating a cooperative relationship between hospital and nursing home administrators.

ANHA Region III (Alabama, Florida, Georgia, Mississippi, North Carolina, and South Carolina) Conference will be held July 24-25, 1961, at the Greystone Hotel, Gatlinburg, Tennessee.

Miss Ann Thompkins of the Florida Nursing Home Association and chairman of the Education Committee for the region, will conduct an educational workshop on July 24th.

Mrs. Viola Caudill of Atlanta, Georgia, Regional Vice President, will be chairman of the business session on July 25th.

Many of those attending the conference plan to spend several days in the area, enjoying the facilities of the Great Smokey Mountain National Park. July is the height of the tourist season; so all who wish to attend the conference are urged to make reservations at the Greystone immediately.

Catherine Anderson, Secretary, Tennessee Nursing Home Assn., is in charge of arrangements.

The Tennessee Nursing Home Association will hold its annual convention August 29-31, 1961, at the Patton Hotel, Chattanooga, Tenn.

The Alexian brothers of Signal Mountain will be hosts at a buffet supper on the terrace of their nursing home on the evening of Aug. 29.

Mr. Gene Thrasher, past president of T.N.H.A., will be the convention chairman. The President of the Tennessee State Medical Association will be the banquet speaker. Mr. George T. Mustin, President, T. N.H.A., will preside at the business session. The theme of the convention will be: "Better Patient Care at Reasonable Rates."

Colorado Nursing Home Association

The Colorado Nursing Home Association held its 8th Anniversary meeting May 22-23, 1961.

The two day conference stressed the Accreditation Program which would promote the improvement of nursing homes through the establishment of basic principles of organization and administration for efficient and kindly care of patients.

The program was introduced to the meeting by Mrs. Margie S. Davis, chairman of Region VI's Accreditation Committee.

The meeting was addressed by Dr. Edward J. Rozek, associate professor of political science at the University of Colorado, and Mrs. Violet Murphy, newspaper reporter.

A panel discussion was held; and a film on fire safety measures was shown by Mr. Verle Root of Boulder, together with demonstrations of fire detection and extinguishing systems. A portable safety bath was demonstrated by Mr. Vern Howell of Howco Distributors of Denver.

Instruction in Self Care

Six Kansas Nursing Home Administrators and personnel attended a special course in *self care* at the Hadley Rehabilitation Center, Hayes, Kansas, April 10-14, 1961.

Ten administrators and staff personnel attended the training course in *self care* at the Kansas University Medical Center, Kansas City, Kan., May 1-5, 1961.

The purpose of these courses is to provide instruction in functional exercise and self care. The goal is to help nursing home residents become ambulatory and less dependent. The courses were sponsored by the Kansas State Board of Health and all expenses are being paid through a special grant.

Other courses will be given in the immediate future at Hayes and the Kansas University Medical Center.

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Our Aging Population Is A National Responsibility

Congressman John E. Fogarty, who sponsored the legislation providing for the White House Conference on the Aging, expressed the hope that it "would create understanding and stimulate action to meet one of the most serious social developments of our time." In January, the conference convened with 2700 participants from all over the country — economists, physicians, gerontologists, nurses, nutritionists, social workers, sociologists, psychologists, and, most important, just plain citizens.

Nursing's Stake

It is much too early to assess the real impact of this conference on all communities which must deal more effectively with the growing problems of our aging population. But, it's obvious that nursing has as great a stake in these problems as any service profession.

That health and medical care — and how it shall be financed — was one of the dominating subjects of the conference was apparent to all. It takes little imagination to recognize that a vast amount of the health care needed by the aging is nursing care. With 77 percent of those over 65 having chronic illnesses, with 42 percent of them suffering limitations of activity due to these disabilities, with those over 65 using twice as many hospital days as the rest of the population, it is obvious that nurses must devote an increasing amount of their skills, attention, and time to geriatric patients.

It seems to us that nurses have taken a rather casual approach to this whole problem of geriatric care. We found it convenient, many years ago, to delegate, both officially and in the actual work situation, the care of the chronically ill (of which the aging are a major part) to the practical nurse and other auxiliary nursing workers. We say, in a vague sort of way, that this care shall be given under the supervision of a professional nurse without defining what "supervision" really means. (A similar kind of medical supervision by the physician is supposed to exist.) If this is a matter of legitimate concern, how can we rely on the too easy answer that such abdication is the only way we can meet today's demands for nursing care? But, does the young person, just returned from the operating room, have greater need for our presence or our skills than the old one in the ward who is more afraid to walk each day?

More and more of the elderly look forward to finding a bed — and too often little else — in America's *nursing* homes. In the last six years, those beds have increased by 79 percent, and the public is crying for many more. But the urgent needs is for more than beds. Although most nursing home residents suffer from two or more physical disabilities, only a third of the nursing home have registered or practical nurses on the staff.

In his foreword to a recently released study of American nursing homes, Senator Pat McNamara, chairman of a senate subcommittee on problems of the aging, states: "The demand for skilled nursing services and rehabilitation for an increased number of disabled older persons is rising and will become more intense as life expectancy increases in the next several decades." The senator recognizes, as probably many citizens do, that the primary problems of nursing homes are problems for nursing. Yet, *nursing* is not there to solve them.

On the other hand, one of the primary concepts developed in the White House Conference was the need to shift our sights from institutional care of the aging to care in the home. If the recommendations from the conference lead to specific action on the national and community levels, one of the results — however it shall be organized and financed — will be more nurses going into the homes of the aging to offer skilled nursing care,

That nurses shall be and must be increasingly involved in the care of the geriatric patient is as clear as the line on our cover. But, more than a fact, more than an obligation, is the opportunity this kind of nursing practice offers to professional nurses. Studying the vocabulary of nursing these days, we hear these words, over and over again: research, psychiatric concepts, public health concepts, support, rehabilitation, and psychosocial understandings. Together, these words are beginning to define an important dimension of the speical professional function of nursing. Where can they be more richly applied than in the care of the geriatric patient?

Too often we hear nurses say, these days, that they are not getting enough satisfaction from practicing nursing. Are there not great promises of satisfaction for the nurse in the care of the aging? In teaching those who consider themselves doomed to helplessness to find new physical independence through the application of rehabilitative nursing principles? In using her initiative and imagination and social knowledge to tap the resources within the patient's immediate community and stimulate him to use them? In using herself to dispel his sense of loneness and unimportance and lend him the security he needs? In helping him perhaps to accept, hopefully to deal with, his health problems.

There is no doubt that this "serious social development of our time" offers vast opportunities for the nursing profession, if we will assume our share of the responsibility for dealing with it.

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An American was seated opposite a nice old lady in the compartment of an English railway car. For several minutes he chewed his gum in silence, then the old lady leaned forward. "It's so nice of you to try to make conversation," she said, "But I must tell you that I'm terribly deaf."

ALFRED S. ERCOLANO

COMMENTS . . .

With regret and a bit of sadness, I recently learned that Dr. Bruce Underwood, Chief of the Nursing Home Service Section, Division of Chronic Diseases, U. S. Department of Health, Education and Welfare, is being transferred to another division of the U. S. Public Health Service. Dr. Underwood is moving to the Office of Vocational Rehabilitation on July 1, 1961.

I have had the pleasure of knowing Dr. Underwood for just a short time; however, in this short period of time I have come to respect him both as an individual and as a dedicated and sincere physician.

Most of you have had the pleasure of knowing Dr. Underwood for quite some years and I am sure that you will miss him as much as he will miss working with you. I am sure that Dr. Underwood will carry with him to his new position the best wishes of all members or our association.

Dr. Underwood's successor will be Dr. J. W. Cashman who has been Director of the Montgomery County, Maryland, Health Department. To Dr. Cashman, we say "Welcome!" and offer him any assistance that our association may be called upon to render.

Dr. Cashman will replace Dr. Underwood as the editior of the "If You Ask Me" column in our Journal.

* * * *

As many of you probably know, the U. S. Senate Subcommittee on Aging, headed by Senator Pat McNamara, Democrat of Michigan, has been elevated to the status of a Special Committee of the Senate.

This Committee is now preparing to conduct public hearings on the CONDITION of NURSING HOMES in the UNITED STATES. The first public hearing will be held in Washington, D.C., and will be centered around conditions in the nursing homes in the District of Columbia. The first hearings will probably be held late in July or early in August.

This office and the President of our Association have offered to help this committee in any way that we possibly can. Over the next few weeks you will probably receive various questionnaires, asking for information on all phases of nursing home activity. Please help us by completing these questionnaires as accurately as you can and returning them to our office as quickly as possible.

If the true picture of conditions in nursing homes is to be presented to the American public, then it is imperative that the nursing home owners and administrators in the country cooperate in the presentation of this picture.

Sincerely,

Alfred S. Ercolano

Executive Director

Only Accredited Hospitals For New York Plan

Associate Hospital Service of New York (AHS), the Blue Cross Plan for New York City and the largest Plan in the country, will no longer consider applications for participating hospital membership from institutions which are not accredited by the Joint Commission on Accreditation of Hospitals (JCAH). The resolution was announced to administrators and presidents of member hospitals in a statement by J. Douglas Colman, president of the organization.

The statement pointed out that a growing interest in hospital standards and the recognition that these standards should be the responsibility of each hospital and its medical staff has been accompanied by the belief that they should be "buttressed by supporting actions of responsible regulatory licensing and financing agencies."

"The standards of hospital care and administration established by the Joint Commission on Accreditation are the most widely accepted, said Mr. Colman. "They have been met by most Blue Cross member hospitals in this area. AHS has been urged both by the recommendations of the Columbia Study and by the Superintendent of Insurance of New York State to make sure accreditation a condition of participating hospital membership."

Accordingly, the board of directors of the Associated Hospital Service unanimously approved a resolution which states its position with respect to nonaccredited institutions. The resolution states that the AHS will take steps – preferably within a three-year period – by which accreditation may become a condition of continuing participating hospital membership for present member hospitals.

(*Reprinted from Barch* 16, 1961, *"Hospitals, J.A.H.A."*)

Big Business in Kansas

The Topeka Capital Journal on Sunday, April 16, 1961, stated that construction of new nursing and personal care homes for the aging has boomed into a multi-million dollar business in Kansas during the past three years, and the upward spiral is continuing this year.

Records of the division of services for the aging in the State Social Welfare Department show that 32 homes were built over the three year period. In the first three months of 1961, plans for 15 more new homes have been submitted with six of the plans already approved.

The division administrator, Mrs. Loudell Frazier, estimated a 50-bed nursing home will cost $250,000 to build. On this basis present planned construction for 1961 would approach the four million mark.

Private individuals, groups and church-related associations operate the majority of the 444 homes licensed in 87 of the state's 105 counties. They have a capacity of 8,639 persons.

Considering that monthly rates at the homes range from about $125 a person to a top of $300, it can readily be seen that nursing and personal care home operation is big business in the state.

New book list published

An up-to-date edition of the brochure on the "Most Useful Professional Texts for Hospital Administrators, Staff Members, Nurses, and Medical Record Librarians" is now available from the Physicians' Record Company, publishers of hospital and medical record forms and hospital textbooks.

New titles have been added, particularly in the field of nursing home administration. Copies of the Book List will be sent at no charge upon request to the Physicians' Record Co., 3000 S. Ridgeland Ave., Berwyn, Illinois.

Plan for Training

(Con't. from page 7)

fields as medicine, rehabilitation, nursing, mental hygiene, geriatrics, and public health, as well as in hospital administration and business management. Training manuals will be written in non-technical language and will include concrete, practical suggestions for nursing home administrators who may not be physicians or nurses. "How-to-do-it" manuals are also to be developed, featuring ideas that owners and administrators can use to increase their efficiency and at the same time improve their services to patients. In addition to the course manuals, a library of reference materials is being compiled, and a one-volume compilation of readers on nursing home administration will be made available.

Information Available

The plan is for courses to be offered eventually throughout the State. More information about the training course may be obtained from Drs. Gerletti and Crawford at Rancho Los Amigos Hospital, 7601 East Emperial Highway, Downey, California.

Tips on Keeping Meat IN SUMMER

Meat Care

Summer weather increases the year-round problem of keeping top quality in the meat we buy. A recent informal survey pointed out the importance consumers place on freshness as a quality guide in meat selection. Yet, the care we give to the meat after we buy it often results in rapid loss of quality, for which we unjustly blame our grocer.

To Keep Quality

It's generally understood that all meats (except some canned ones) must be refrigerated at 38 to 40° F. to keep quality. Also known, but often ignored, is the fact that meat should be taken straight home from the grocery store and refrigerated immediately. Not so well understood is: how to prepare the meat for refrigeration and how long it can be kept without serious quality loss. Another point of confusion is the difference in treatment needed by cooked and fresh meats.

To keep freshness in uncooked meats, place them in the meat compartment or other very cold area of the refrigerator (38 to 40° F.) soon after purchase. If meat is wrapped in market paper, remove wrapping and re-wrap it loosely in waxed paper or foil to allow free circulation of air. Also loosen wrappings on pre-packaged fresh meats before placing them in the refrigerator.

Hold a Few Days

Steaks, chops, and small roasts can be held in a good refrigerator for 2 to 3 days; larger roasts for slightly longer. For best eating quality, ground or cubed meat and variety meats should be used within 24 hours after purchase or stored in a freezer.

Hams and picnics that are cooked before we buy them keep top flavor in the refrigerator for only three or four days. After that time, they are still usually safe to eat, but odor and flavor changes begin to develop. So, when you have a larger supply of commercially cooked meat on hand than you'll use in two to three days, it's best to freeze it in the size packages you'll use for one meal.

Large Cuts May be Held

Home cooked roasts and larger cuts may be safely held in the refrigerator for four or five days, if properly cooled and wrapped. Though uncooked meat keeps best when wrapped loosely, cooked meats should be covered or wrapped tightly to prevent drying. Like fresh meats, cooked meats should be stored in the coldest part of the refrigerator. It's a good idea to let cooked meat cool at room temperature about one hour after cooking before storing it in the refrigerator.

Sample Menus . . .

(For Those Not Requiring Special Diet)

Ask a person about his nursing home and he will likely tell you about the food. Food that tastes good goes a long way toward keeping nursing home residents happy. Food that meets the daily nutritional needs of the residents goes even further toward keeping them well.

For some, good planning and preparation of the normal diet is enough; others need special diets; those who can take normal diets but have trouble chewing need to have some foods ground or chopped.

A diet that satisfies the wants of the people in your home might not satisfy their needs. Check yourself each day to see that you are providing for each patient, (1) at least a pint of milk as a beverage or in cream soups, custards, or creamed foods; (2) two or more servings (two or three ounce size) of high quality protein; (3) four or more half-cup servings of vegetables or fruits, (include in this group a good source of Vitamin C each day and a green or yellow vegetable every other day); (4) four or more servings of enriched bread or cereal. Other foods should be included as needed to complete meals and provide needed food energy. Except in specific instances, no bread or beverage (other than milk) has been listed in menus below:

* See Enclosed Receipes For:
Fourth of July Ribbon Salad
Melon Ball Salad
Baked Hamburger Steaks

	4	5	6
Breakfast	Blended Citrus Juices Farina — Milk Omelet — Bacon Strip Toasted Sweet Roll	Stewed Prunes Dry Cereal — Milk Poached Egg on Toast Strawberry Jam	Apple Juice Cream of Wheat Cooked in Milk Jelly Omelet Buttered Toast
Lunch or supper	Baked Cube Steak — Mushroom Sauce Oven Browned Potato Cubes Steamed Brussels Sprouts Molded July 4th Ribbon Salad* Hot Buttered Rolls White Layer Cake — Chocolate Topping	Baked Macaroni and Cheese Baby Green Lima Beans Sliced Tomato Baked Apple with Cream	Country Fried Steak Baked Potato Steamed Cabbage Pineapple and Cottage Cheese Salad Lime Sherbet
Dinner	Ham and Chicken Salad Assorted Fruit Plate Crackers Cherry Cobbler — Ice Cream Milk	Beef Stew with Vegetables Buttered Brussels Sprouts Corn Muffins Watermelon Milk	Egg Cutlet — Mushroom Sauce Green Beans Carrot and Raisin Salad Bran Muffins Congealed Strawberry Pie Milk

	11	12	13
Breakfast	Pineapple Juice Scrambled Eggs Buttered Toast Apple Jelly Milk	Blended Citrus Juice Hot Oatmeal with Crushed Pineapple — Milk Crisp Bacon Slices French Toast	Fresh Orange Juice Waffle Square — Melted Butter — Maple Syrup Crisp Bacon Milk
Lunch or supper	Meat Loaf — Ketchup New Potatoes in Cream Sauce Dandelion Greens Shredded Carrot and Pineapple Salad Raisin Pie	Braised Lamb Shoulder Chops Potatoes Au Gratin Seasoned Mixed Vegetables Cherry Cobbler Alamode	Baked Liver Loaf Mashed Potatoes Stewed Tomatoes Pear and Orange Salad Fresh Strawberries with Sponge Cake
Dinner	Cold Sliced Corned Beef Baked Corn Pudding Okra and Tomato Gumbo Whole Wheat Bread Individual Egg Custards Lemonade	Clam Chowder Saltines Peach and Cottage Cheese Salad Pumpkin Custard Pie Milk	Creamed Chicken on Toast Buttered Spinach Tomato Aspic Salad Peach Cobbler Milk

	18	19	20
Breakfast	Sliced Banana with Corn Chex — Milk French Toast Crisp Bacon Slice	Stewed Rhubarb Soft Cooked Egg Bran Muffin — Butter Apple Jelly Milk	Blended Citrus Juices Scrambled Eggs Crisp Bacon Buttered Bran Muffins Milk
Lunch or supper	Roast Lamb, Mint Jelly Oven Browned Potatoes Steamed Okra Grated Carrot and Raisin Salad Whole Wheat Muffins Blackberry Cobbler	Baked Pork Chops in Mushroom Soup Steamed Rice Spiced Apple Ring Angel Food Cake with Fresh Strawberry Topping	Braised Beef Short Ribs Franconia Potatoes Carrots and Peas Finely Chopped Cole Slaw with Honey-Ginger Dressing Apple Cobbler
Dinner	Assorted Cold Meats with Cheese and Deviled Eggs Shredded Lettuce — French Dressing Whole Wheat Bread Fresh Peach Ice Cream Milk	Chicken Salad Escalloped Potatoes Mixed Greens Muffins — Butter Fruit Compote with Lemon Sauce Milk	Lamb Patties — Gravy Fluffy Boiled Rice Buttered Broccoli Apple Betty — Cream Milk

	25	26	27
Breakfast	Chilled Kadota Figs Assorted Dry Cereal — Milk Cheese Omelet Raisin Toast	Fresh Berries — Cream Farina — Milk or Cream Soft Cooked Egg Crisp Bacon Slice Bran Muffin — Butter	Blended Grapefruit and Pineapple Juice Wheat Chex — Fresh Berries Milk Poached Egg Crisp Bacon Slice Buttered Whole Wheat Toast
Lunch or supper	Beef Stew with Vegetables Buttered Chopped Broccoli Harvard Beets Pear and Cottage Cheese Salad — Mayonnaise Hot Corn Bread Coconut Meringue Pie	Lamb Patties Sauteed Pineapple New Potatoes in Cream Sauce Seasoned Green Beans Ice Cream — Pound Cake	Pan-Broiled Ham Slice Duchess Potatoes Fresh Asparagus, Hollandaise Sauce Molded Fruit Salad Pineapple Upside-Down Cake
Dinner	Whole Meal Sandwich (Cheese, Sandwich Meat, Lettuce and Relish) Buttered Broccoli Sliced Tomatoes Lemon Icebox Pie Milk	Okra and Tomato Soup Pimiento Cheese Sandwiches Boiled Cabbage Corn Sticks Cantaloupe Strawberry Milk Shake	Breaded Hamburger Steaks Cream Gravy Buttered Rice Chopped Mixed Greens Brown and Serve Rolls Chocolate Milk Cookies

. . . for a Month

	1	2	3
Breakfast	Sliced Bananas Assorted Dry Cereal or Oatmeal — Milk Scrambled Eggs Crisp Bacon Raisin Toast	Grapefruit Sections Maltex Cooked in Milk Poached Eggs Buttered Toast	Fresh Orange Juice Assorted Dry Cereal with Milk Soft Cooked Eggs Whole Wheat Toast Apple Jelly
Lunch or supper	Roast Veal Candied Yams Seasoned Kale Greens Shredded Carrot and Pineapple Salad Blueberry Cobbler	Steamed Chicken Snowflake Potatoes — Gravy Buttered Squash Cranberry Sauce Hot Rolls Lemon Pie	Spanish Steak with Vegetable Sauce Steamed Rice Chopped Seasoned Spinach Fruit Cup
Dinner	Cream of Tomato Soup Cold Sliced Ham and Cheese Saltines Potato Salad Orange and Honey Ambrosia Milk	Tunafish Salad Potatoes in Jackets — Butter Buttered Asparagus Brown Bread Chilled Apricots Sugar Cookies Milk	Cream of Potato Soup — Crackers Cold Sliced Turkey and Ham Whole Wheat Bread Shredded Lettuce Salad French Dressing Blueberry Cobbler Milk

7	8	9	10
Orange Sections Wheatena — Milk Soft Cooked Egg Buttered Toast	V-8 Cocktail Assorted Dry Cereal — Milk Hot Cakes — Syrup — Melted Butter Crisp Bacon	Chilled Blended Fruit Juice Cream of Wheat, Cooked in Milk Poached Egg on Toast Crisp Bacon	One half Grapefruit Hot Oatmeal or Cold Cereal — Milk Soft Cooked Egg Whole Wheat Toast Jelly
Baked Salmon Loaf Creamed New Potatoes with Frosted Green Peas Jellied Vegetable Salad Pears — Sponge Cake	Grilled Ham — Fruit Sauce Parsley Buttered Potatoes Buttered Brussels Sprouts Finely Chopped, Mixed, Green Salad — French Dressing Apple Crisp	Roast Turkey — Giblet Gravy Dressing Green Cut Beans Cranberry Sauce Ice Cream — Sponge Cake	Beef Stew with Vegetables Finely Chopped Cole Slaw Corn Muffins Floating Island
Cheese Souffle Crisp Bacon Mixed Greens Green Lima Beans Fruit Jello with Peanut Butter Cookies Milk	Deviled Eggs Thin Sliced Cold Beef Tongue Boiled Potatoes in Jackets Buttered Whole Okra Whole Wheat Bread Raisin-Rice Custard Milk	Cream of Turkey Soup Saltines Pimiento Cheese Sandwiches Finely Chopped Spinach Salad Cantaloupe Milk	Broiled Hamburger Patty Thin Sliced Buttered Carrots Sliced Tomatoes Pineapple Upside Down Cake Ice Cream Milk

14	15	16	17
Grape Juice Assorted Dry Cereal with Milk Poached Egg on Whole Wheat Toast	Grapefruit Juice Corn Flakes — Milk Scrambled Eggs Raisin Toast	Broiled Grapefruit Half — Brown Sugar Assorted Dry Cereal or Malt O' Meal Steamed Egg — Crisp Bacon Buttered Toast	Chilled Fresh Peach Slices Special K — Milk Poached Egg on Whole Wheat Toast
Breaded Cod Fillets Tarter Sauce Parsley Potatoes Creamed Spinach Grapefruit and Orange Salad Angel Cake with Chocolate Syrup	Baked Salisbury Steak with Brown Gravy Steamed Rice Stewed Okra and Tomatoes Vegetable Relish Prune Cake — Butter Icing	Smothered Chicken, Gravy Snowflake Potatoes Green Beans Raw-Relish Bowl Rhubarb Shortcake, Dessert Topping	Tuna Cheese Puff Braised Celery and Carrots Baked Potato Beet Relish Pear and Plum Compote
Macaroni and Cheese Crisp Bacon Buttered Whole Okra Citrus Fruit Salad Bran Muffins Assorted Cookies Milk	Meat Balls in Vegetable Sauce Baked Potatoes — Butter Congealed Fruit Medley Salad Hot Buttered Rolls Cantaloupe Milk	Celery, Chicken and Rice Soup Saltines Brown Bread — Cheese Sandwiches Fresh Strawberries — Cookies Milk	Jellied Consomme Baked Corn Beef Hash Buttered Cabbage Corn Sticks Refrigerator Cookies Milk

21	22	23	24
Chilled Apple Juice Cream of Wheat with Grapenuts Crisp Bacon Slices Buttered Hot Rolls	Grapefruit and Orange Sections Hot Oatmeal — Milk Cinnamon Toast	Blended Citrus Juices Assorted Dry Cereal — Milk Scrambled Eggs — Ham Buttered Toast	Fresh Fruit in Season Malt O' Meal — Milk Poached Egg on Toast Crisp Bacon Slice
Oven Browned Fish Sticks Baked Potato Cubes Buttered Mixed Vegetables Corn Sticks Fresh Arkansas Sliced Peaches	Spaghetti with Meat Sauce Chopped Vegetable Salad French Dressing Strawberry Shortcake	Roast Turkey — Toasted Rice Stuffing Caramel Sweet Potatoes French Green Beans Melon Ball Salad* Lemon Meringue Pie	Roast Ribs of Beef — Natural Gravy Mashed Potatoes Fresh Sliced Tomatoes Citrus Fruit Salad Cottage Pudding
Cream of Celery Soup Saltines Boiled Ham and Cheese Sandwiches Fresh Citrus Salad Vanilla Pudding Milk	Creamed Dried Beef on Toast Buttered Spinach Glazed Carrots Gingerbread with Chocolate Sauce Milk	Turkey-Vegetable Soup Buttered Toasted Crackers Assorted Fruit Plate Peanut Butter Muffin Egg Custard Milk	Baked Breaded Hamburger Steak* — Gravy Buttered Rice Steamed Buttered Okra Congealed Fruit Salad Fresh Fruit Milk

28	29	30	31
Fresh Orange Juice Rice Krispies — Milk French Toast Crisp Bacon Slice Syrup — Honey	Chilled Stewed Prunes Cold Cereal — Fresh Fruit and Milk Soft Boiled Egg Crisp Bacon Slice Buttered Hot Roll Jelly	Fresh Peach Slices— Cream & Sugar Assorted Cold Cereal Scrambled Eggs Buttered Toast Apple Jelly Milk	Blended Citrus Juices Hot Oatmeal — Milk Waffle Square — Melted Butter — Honey Crisp Bacon Slice
Tuna-Noodle Scallop Potato Chip Topping Seasoned Dandelion Greens Mixed Fruit Salad Gingerbread Cupcakes Lemon Sauce	Baked Liver Loaf, Natural Gravy Baked Stuffed Potato Steamed Mixed Greens Slice Tomato on Lettuce Orange Tapioca Pudding	Oven Browned Beef Roast — Natural Gravy Steam Rice Glazed Carrots Chopped Green Salad — Thousand Island Dressing Lemon and Raisin Sponge Pudding	Baked Ham Candied Yams Seasoned Green Beans Pineapple and Cottage Cheese Salad Apple Cobbler — Cream
Macaroni and Cheese Crisp Bacon Green Beans Fruited Harvard Beets Apple Cobbler — Coffee Cream Milk	Boiled Ham Sandwiches Green Asparagus Tips in Cheese Sauce Congealed Peach and Pear Salad Strawberry Chiffon Pie	Salmon Loaf Potato Salad Citrus Fruit Salad Corn Muffins Caramel Custard Milk	Baked Corn Beef Hash Buttered Asparagus Escalloped Tomatoes and Okra Banana Pudding Milk

Recipes for Sample Monthly Menus

FOURTH OF JULY RIBBON SALAD

(25 servings)

21 oz. of lemon gelatin
7 Cups of hot water
7 Cups of cold water and liquid from diced pears
2 cups of shredded celery
10 cups of diced pears
21 oz. of cherry gelatin
7 cups of hot water
7 cups of cold water and liquid from crushed pineapple
8 cups of crushed pineapple

Dissolve the lemon gelatin thoroughly in hot water. Add cold liquid. Chill until slightly thickened. Add shredded celery and diced pears. Pour into molds or pan and chill until firm .

Dissolve cherry gelatin thoroughly in hot water. Add cold liquid. Chill until slightly thickened. Add the crushed pineapple and pour over the firm lemon gelatin.

18 oz. of lemon gelatin
12 cups of hot water
12 oz. of cream cheese
6 cups of heavy cream — whipped

Dissolve the lemon gelatin thoroughly in hot water. Gradually add to the cream cheese, blending until smooth. Chill until slightly thickened. Fold in whipped cream. Blend thoroughly. Tint blue with blue vegetable coloring (4-5 drops). Gently spread over the firm gelatin mixture. Chill until firm.

Cut in squares and serve on lettuce. Garnish with red Maraschino cherry or ripe strawberry.

MELON BALL SALAD

(25 servings)

6 cantaloupes
12 cups of watermelon balls
12 cups of honeydew melon balls

Slice the cantaloupe into rings about an inch thick. Peel each ring and place on lettuce. Fill each ring with watermellon and honeydew balls. Garnish with sprig of mint or parsley. Serve with lemon mayonnaise or French Dressing.

BAKED HAMBURGER STEAKS

(25 servings)

6½ pounds of ground beef
1 tablespoon salt
5 eggs
½ cup of milk
3-4 cups of finely crushed cornflakes

Make 4-ounce hamburger steaks from ground beef — shaping steaks in rectangles one-half inch thick. (Shape the steaks gently so you do not pack hamburger tightly. Packing ground beef makes the steak tough and hard.)

Beat eggs and milk together until thoroughly mixed. Dip each steak into milk, then into finely crushed cornflakes.

Bake in slightly greased heavy pan which you have preheated. Cook only until outside is brown and pink has disappeared from center (15 to 20 minutes at 400° F.)

PENNY WISE MENUS

POLISH-AMERICAN POT ROAST OF BEEF

Onions, Carrots Gravy
Fresh Vegetable Salad
Hot Buttered French Bread
Fresh Pineapple Slices with Ice Cream
Milk — Tea

OVEN BAKED FRYER

Corn on Cob Baked Green Beans
Tomato and Cottage Cheese Salad
Whole Wheat Bread Butter
Lemon Cake Dessert Milk

GOOD BUYS

POULTRY — Fryers.

PORK — Hams and picnics, fresh roasts and steaks, sausage.

BEEF — Ground meat, chuck, round steaks.

OTHERS — Eggs; lunch meats, liver, franks; tuna, Frozen seafoods; cake mixes; mellorine, dairy products.

VEGETABLES — Potatoes, greens, cabbage, celery, corn, beets, squash, lettuce, onions, carrots, dried peas, beans, rice.

FRUITS — Bananas, pineapples, oranges, grapefruits; raisins; canned and frozen fruits, vegetables and juices.

POLISH-AMERICAN POT ROAST OF BEEF

4 to 5 lb. round bone beef pot roast
8 slices bacon
2 tbsps. lemon juice
1 tsp. salt
1/8 tsp. pepper
4 medium carrots, pared and quartered
6 medium onions, peeled
4 peppercorns
1/2 cup water

Cut the bacon into small pieces. Cook the bacon in a heavy kettle. Remove the bits of bacon from the kettle. Pour off all but 2 tbsps. of the drippings. Brown the pot roast in the bacon drippings. Slip a rack under the roast in the kettle. Add the bits of cooked bacon and remaining ingredients, except onions and carrots. Cover tightly and simmer 2 to 3 hours or until fork-tender. Add onions and carrots during last 30 minutes of cooking. Make gravy by thickening drippings in the pan with flour.

BAKED GREEN BEANS

(A little expensive, but different)

2 (10 oz.) pkgs. frozen green beans, French style
1 (10 1/2 oz.) can condensed cream of mushroom soup
1 (3 1/2 oz.) can French fried onions

Partially cook green beans as directed on package. Mix with soup and pour into 1 1/2 quart baking dish. Top with onions. Bake in moderate oven (375°) 15 to 20 minutes or until beans are tender. (May be baked with fryer at 400° for 12 to 15 minutes.) Makes 6 servings.

LEMON CAKE DESSERT

1/4 cup flour
1 cup sugar
1/2 tsp. salt
3 egg yolks, well beaten
1/4 cup lemon juice
1 1/2 cups milk
1 tbsp. grated lemon rind
3 egg whites, stiffly beaten

Sift together flour, sugar and salt. Blend together egg yolks, fruit juice, milk and rind. Combine liquid and dry ingredients; beat until smooth. Fold in egg whites. Pour into greased 8 x 8 x 2" pan; place in larger pan of hot water. Bake in slow oven (325°) 45 minutes. Serve warm or cold, cut in squares. Makes 6 servings.

Concepts in Rehabilitation of Aging Patients

By J. L. RUDD, M. D. and
REUBEN J. MARGOLIN, Ed. D.
Veterans Administration Hospital
Brockton, Massachusetts

For the past decade we have been witnessing a significant transition from the "talk" stage to the "do" stage in regard to the aging. The pressure of an increasing geriatric population primarily accounts for the welcome change. We can no longer ignore the well known, frequently quoted, statistics such as:

1. *Sixteen million persons, or approximately one tenth of our population, are more than 65 years of age.*

2. *During the past half-century the number of persons over 65 has quadrupled while those under 65 has only doubled.*

3. *By the year 2000 the number of persons more than 65 years old is expected to be about 27,000,000 or approximately 16 per cent of our population* (1).

Although medical science has contributed toward increasing the life span, employment opportunities for persons past the age of 50 generally have declined. With an increase in life expectancy there is an obvious increase in multiple disabilities, both physical and mental. We disagree with those who believe that such people cannot be rehabilitated to gainful employment and that the goal should be primarily that of custodial activity. It is our experience that even with severe multiple disabilities, an appreciable number of persons in the older group can be successfully rehabilitated to employment. This paper will attempt to describe a method that appears to be effective.

Concept of Dynamic Rehabilitation

Many of those who work with the aged now realize that they must change their approach from a traditional "laissez-faire" method to one that has a more dynamic orientation. The dynamic approach implies that treatment and rehabilitation must be based upon an understanding of the life patterns of the individual before there can be any hope of success in achieving the ultimate goal of selective placement.

Successful dynamic rehabilitation involves genuine cooperation within the hospital as well as between the hospital and the community. In the hospital setting, a complete physical medicine rehabilitation program that harmonizes closely with counseling psychology is essential. Shatin (2) has already reported on 2 projects which demonstrated that comprehensive rehabilitation profoundly influences psychologic remotivation in the aged. In the community setting, Rudd and Feingold (3) have stressed the need for cooperation between the physician and the vocational counselor. Hilleboe *et al.* (4) described a pilot program for the rehabilitation of disabled adult welfare recipients. They concluded that there exists an unknown but sizable number of welfare recipients, now totally disabled, who could benefit substantially from intensive rehabilitation including vocational counseling and placement, if the opportunity were extended to them.

The presence of multiple handicaps should not be a deterrent to an active over-all rehabilitation program. Instead, the physician must determine to what extent handicaps prevent participation in certain activities. He must also determine which handicaps are likely to improve as a result of participation in rehabilitation activities. The physician must be continuously alert to the manner in which the aging person reacts to his environment. In this way residual liabilities can be minimized and the patient encouraged to capitalize upon his assets as they are manifested. Thus, the physician must be alert to both physical and mental conditions that impede or facilitate the progress of rehabilitation.

THE AUTHORS

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The Authors Concept of Moderate Push

Rehabilitation by "total push" should be supplanted by a newer concept based on the "moderate push" principle. Most older, hospitalized patients fare better when treated under the "moderate push" plan; then they become involved in physical, mental and social activities according to their tolerance level. By moderation one avoids the physical aches, the mental exhaustion and the inevitable future refusals that are incurred when a formerly overworked patient is again asked to participate in a planned program or work schedule.

The physician in charge of the geriatric ward should be depended upon to supply the nutritive supplements containing vitamin C, niacin and iron, the heart tonics such as nikethamide or digitalis, and the tranquilizers and sedatives as needed.

Important to a person in the aging category is the satisfaction of his phychodynamic needs, especially those pertaining to recognition, security, being accepted, and belonging to a group. In fact such needs may be intensified because of the family's or community's unthinking attitude, which tends to relegate the old person to the scrap heap. Since psychodynamic needs vary with the individual, measures should be utilized which can evaluate these needs. With this knowledge an appropriate rehabilitation program can be planned. Assessment should be carried out through clinical interviews, psychologic testing, and observations of specific performance in rehabilitation activity. Since needs continuously change, assessment should be continuous.

Rehabilitation Modalities

Prescription of treatment by the

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physician must be based upon the foregoing medical and psychologic data. In this connection, all the modalities of the Physical Medicine & Rehabilitation Service which include physical therapy, corrective therapy, educational therapy, manual arts therapy, and industrial therapy should be utilized. In some mental hospitals which have an advanced rehabilitation program, an additional activity known as the Member-Employee program may be prescribed (5). The main emphasis in the Member-Employee program is on work conditioning and social adjustment. Patients are discharged from the hospital, but are permitted to live in their own dormitory quarters in the hospital and receive a salary for their work. They are expected to fulfill the same obligations and responsibilities as any other employee in the hospital. This program is a sort of crowning achievement to the patient's rehabilitation progress. It serves as an important transitional bridge from the hospital to the community. The Member-Employee program can be extremely useful in the rehabilitation of those aged that reach this advanced level. It gives impetus to self-esteem and to productivity living. Under this program, selected geriatric patients can profit greatly from work conditioning under close surveillance.

In employing these modalities it is important to stress that all activities must be graded in accordance with individual needs. It is a step-by-step climb up the rehabilitation ladder. However, with the aged, the progress is neither smooth nor continuously upward. There are reversals and regressions. Indeed, periodic regression, even with a patient considered successfully rehabilitated, is to be expected. Despite these expected temporary setbacks the successfully rehabilitated aged person will be able to function adequately.

Stress on occupational goals begins when definite signs of progress are noted in the physical medicine program. If the patient demonstrates certain abilities and potentials, then a complete vocational testing program should be carried out at this time. Testing should include not only intelligence, personality, aptitude and interest tests but also a physical demands capacity test. It is necessary to determine whether the patient is intellectually, emotionally and physically capable of doing the job. Whenever possible, it would be advisable within the hospital setting, to provide the patient with a type of work experience that would test these 3 qualities. Observations of specific performance in a controlled setting seem to provide the most important clues for selective job placement in the community.

Case Reports

To illustrate the rehabilitation process with the aged, two case reports are presented:

Case 1

M. S. was a male, 64 years of age. He suffered from some of the handicaps that older people are likely to have. He had diabetes, arteriosclerosis and a hernia. Medical treatment, including rehabilitation through a Vocational Service, permitted him to stay active and alert, physically and mentally.

The counselor was very much impressed with the client's confident attitude of success and general business "know-how," and suggested as the initial step that Mr. M. S. look for a suitable location for a small jewelry business. One could readily see the difference in the patient's attitude once he started his own business. The new cheerful, happy person was indeed a different man from the depressed aging person originally interviewed. He was soon making a living and, what was most gratifying to him, was his ability to repay his business loan in half time granted him.

Comment. The counselor believed that looking toward the future should include some consideration of self-employment for people past their prime of life and those approaching the traditional retirement age of 65 years. Regardless of the person's age, moderate infirmities and handicaps, a well-selected small business may mean the difference between happiness and longevity, or despair and premature death. The wide range of self-employment opportunities makes it possible for an older person to select a business to suit his needs, and as his own boss he is able to set his own pace. The fact that the major goal is a moderate income, purposeful activity and an increased feeling of security rather than an ambition for large and increasing income, makes it easier to work with most older people.

Case 2

This 69-year-old white veteran of World War I had been hospitalized for twenty years. His symptoms first developed after he had suffered some business reverses. He had paranoid delusions, and became antisocial, selective and resistant to treatment. Pulmonary tuberculosis was discovered during a routine chest x-ray examination about eleven years after he was hospitalized as a mental patient. There was extensive bilateral infiltration of the upper lobe, more marked on the left. He was treated by brushing of the left phrenic nerve, and also with streptomycin and isoniazed. The condition cleared remarkably over a period of several years.

He was never suicidal or assaultive, but fluctuated between being over-suspicious, noisy and resistive to treatment and being quiet and cooperative. He thought his sputum had some special properties and was unwilling to part with any of it. Insight and judgment were somewhat defective. His mental condition showed little change up to the time chlorpromazine was started, approximately a year before his discharge. He changed from a hostile, angry person to one who was much more pleasant and approachable.

In the physical medicine rehabilitation program he was advanced from Occupational and Manual Arts Therapy to an individual Industrial Therapy assignment. His performance was good and he showed good aptitude as a furniture repairman and a greenhouse worker. He was therefore recommended for the Member-Employee rehabilitation program. At first he resisted attending, and claimed it was a plot to keep him in the hospital. After ventilating his fears and anxieties he accepted a job assignment on the Member-Employee program as a furniture repairman. His work adjustment was excellent.

He was discharged from the program after four months, when a job in the community was secured for him as a greenhouse worker. At the same time he was placed in a foster

(Con't. on page 18)

CAPITOL

LABOR-MANAGEMENT RELATIONS: A witness before a House Labor Subcommittee studying the National Labor Relations Board, made the following statement:

"The conditions of Labor-Management Relations affects all segments of the economy, not just the parties involved. The prevalence of featherbedding at missile sites means increased government spending which you and other taxpayers can ill afford; strikes at these installations jeopardize the security of employers and employees alike.

"And wage settlements in basic industries can set off chain reactions that lead to pay raise demands in industries only remotely connected with the original dispute.

"So relations between management and labor are of concern to all businessmen and employees, as well as the general public. For this reason, it is imperative that the laws governing these relations be fairly administered without prejudice to either side.

"One government agency charged with this task is the National Labor Relations Board (NLRB). The Board, under the law, must be impartial. It should be also expeditious in disposing of cases. As the saying goes, 'Justice delayed is justice denied'."

Two witnesses reminded the subcommittee that one of the factors hindering the Board has been its extensive time-lag in deciding cases. These delays have been caused by the enormous number of disputes thrust upon the Board for adjudication.

To alleviate the situation, it was proposed that the requirements for NLRB jurisdiction be made more stringent, with non-eligible cases turned over to state courts and agencies for settlement.

If the increase in the standards for NLRB jurisdiction does not materially reduce the Board's backlog, the witness said, "the NLRB should be abolished completely and the rights, duties, and responsibilities of employers and employees should be written into law to permit anyone to go freely into court to protect his rights."

SOCIAL SECURITY EXPANSION: Present indications are that the House Ways and Means Committee may start hearings around July 10th on the King bill (H.R. 4222) initiating compulsory health care plan under Social Security System.

INFLATION AND SPENDING CONTROL

Postal Subsidy: House Post Office Committee plans to continue hearings this week on the Murray bill (H.R. 6418) that would increase postal rates to provide $741 million annually to reduce the postal subsidy of nearly $3 million each working day.

After hearings are ended, Committee plans to consider action on the rate-increase bill. Letters to members of the Committee, and to your Congressmen, will help encourage action!

TAX REFORM

House Ways and Means Committee to conclude hearings on Administration tax proposals on June 9, and thereafter to meet behind closed doors to consider what action to take. Advance reports are Committee may do little more than to report out bill extending corporation and excise taxes expiring June 30, although possibility exists of action to impose withholding tax on dividends and interest.

ECHOES

(Con't. from page 16)

home about two miles from his work. Despite his age, he walked to and from work daily. Both the social worker and the Member-Employee supervisor, who was a counseling psychologist, conducted close supervision for a long period of time. After living in his foster home for almost two years he requested permission from the employer to convert an unused garage, located on the greenhouse grounds, into living quarters so that he could be near his work. Permission was granted and he performed all the alterations, construction and painting necessary to convert the garage into decent living accommodations. He has been working for a period of four years and is still "going strong."

Comment. This single case had already cost the federal government about $100,000. Through successful rehabilitation the seemingly permanent and continuing cost was eliminated. Furthermore, over the past four years this man has returned to the Government in income taxes approximately $2,500. In addition to the economic aspect, there was considerable improvement in the psychologic area, *i.e.*, self-esteem, feelings of adequacy, better interpersonal relations, and increased zest for living.

This example of successful rehabilitation of an aged person is not an isolated case. The Member-Employee program has treated other aging persons with multiple handicaps by securing employment for them in the community. Table 1 shows the ages of these persons and the jobs taken.

TABLE 1

Jobs Taken by Member-Employees in the Aging Category*

Age Group (yrs.)	No. of Persons	Job
50-54	9	Laborer, nurse, truck helper, crane operator, carpenter, butcher, maintenance man, telephone operator, janitor.
55-60	5	Foundry worker, kennel worker, stock clerk, invoice clerk, maintenance man.
61-65	3	Kitchen helper (2 patients), greenhouse worker.

*The average length of hospitalization of these patients before taking part in the Member-Employee program was ten years; one patient had been hospitalized more than twenty-five years, and another for more than thirty years. Only 2 of this group are not working today.

Summary and Conclusions

A more optimistic outlook on geriatric rehabilitation has been emphasized. It is necessary to advance beyond the "keep busy" approach and the attitude that the hospitalized aged are permanent custodial problems with little prospect of becoming useful citizens again.

It has been clearly demonstrated that a fair percentage of old people, even with multiple handicaps, may be successfully rehabilitated. The process whereby this can be accomplished has been outlined, with special emphasis on the concepts of selective placement and the "moderate push program" in contrast to a better known and frequently used "total push program." Patients should be encouraged to set their own pace; work for part of the day should be acceptable if a full day's work is not physically or mentally advisable. Two cases excerpts and some statistical information have been presented.

It is hoped that this brief report may encourage others who deal, or may have to deal, with the increasing geriatric population. If we can reorient our perceptions and change to a more dynamic approach in geriatric rehabilitation, the future will be more promising.

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Supplying Nutritional Needs of Older Persons

(Con't. from page 4)

he prefers hot cereal to cold cereal.

The serving of the food has its important place in the scheme of things. All the residents that are able, should be served in a dining room. Getting together at mealtime takes away the feeling of being alone and makes mealtime an occasion for visiting and seeing many of the other residents. Companionship in pleasant surroundings should help to perk up appetites.

If food needs to be served on trays, the trays should be attractive and have some color to make it appealing. When a colorless meal is served, it does little to perk up one's appetite or stir the imagination. We not only need a variety of color, but we should have different textures in a meal. Do not serve mashed potatoes and mashed turnips in the same meal. Be sure that when the food is served, it is served hot. If a resident needs help in eating, be sure to serve his tray when you are ready to feed him, and do not let the food become cold. Also, if you really want the person to eat, you should allow plenty of time to feed him, so that he will not think you are trying to hurry him and that it is a burden for you to spend the time with him. You can coax many a poor eater to try the different foods good for him, if you are just willing to take the time to visit with him about the need for the food, and show him that you are willing to spend some time with him to help him eat.

Need Smaller Meals

Some older people do better with smaller meals, and in between meal snacks. Whenever you serve snacks, be sure to serve foods that have some nutritive value and are not mostly calories. Snacks or between meal feedings are a part of our present day eating pattern. These snacks should be considered in the over-all planning for the day. Snacks can

come from any of the basic food groups mentioned earlier. Many homes serve fruit juice, cookies, milk, or ice cream in the afternoon or before bedtime. Milk at bedtime is as good as a sleeping pill.

As many of you know there is another problem to meet in getting people to eat the proper foods. Many have the problem of dentures or no teeth at all. However, you shouldn't let this be a reason for their eating all soft, washed or strained foods. Many foods might be cubed, chopped fine, or just cooked to be tender. Meat or chicken could be cut into small pieces, and be creamed or combined with peas. rice or noodles. Fish is easy to chew when prepared in most of the usual ways. American cheese is easy to eat if finely divided or melted and served over broccoli or with macaroni or as an omelet. I have found, in my association with people, that lots of older people have been without their teeth so long that the gums have become so hardened that they can eat most kinds of food if they like them. Of course, you do not want them to eat hard foods that will be chewed poorly and thus cause discomfort when the food reaches the stomach.

Balanced Diet Needed

I know you have many problems when it comes to feeding a well-balanced diet to most of our older citizens. I do not have all the answers to all of these problems. I am sure no one does. Each home has to work with each individual in the home, with his family eating pattern plus his own likes and dislikes. You can not throw all old people into one category and thus come up with one diet or menu to serve all old people.

My only hope is that each and everyday you plan and serve a well-rounded diet to your patients. If you plan an adequate diet each day, they will be sure to get many of the foods they need to be healthier and happier, and life will be more pleasant for those around them.

Everyone eats and, therefore, is an expert on the subject. No wonder that there is a fabulous mixture of ignorance and knowledge in matters nutritional.

Medical Records Study Makes Progress

By ELDRED THOMAS, 1st Vice President,
American Nursing Homes Association

On September 15, 1960 the federal government signed its first negotiated services contract with any proprietary nursing home group. Acting through the nursing home section of the Chronic Disease Program, the Public Health Service signed a contract with the Texas Nursing Home Association which provided for a development of nursing home records which would cover the entire scope of nursing home operation. The Texas Nursing Home Association appointed Eldred Thomas, who had been negotiating with the Department of Health, Education & Welfare for the past two years, as Chairman of the Steering Committee to develop these records.

The Department of Health, Education and Welfare is hopeful that this study will be accepted by the Governing Council of the American Nursing Home Association and will be recommended to the nursing homes in the United States.

The Steering Committee of the Medical Records Study is composed of Eldred Thomas, 1st Vice President of American Nursing Home Ass'n. and Chairman of the committee; J. W. Hornburg, Chief of the Nursing Home Licensure Section of the State Health Department of Texas; H. R. Goehrs, M. D., a physician who is active in the field of geriatrics; W. B. Forster, Administrator, Bexar County Hospital System, San Antonio, Texas; Laura M. Koetting, Medical Records Librarian, a graduate of St. Louis University with a B. S. degree from the University of Missouri and an M. S. degree from Colorado University; and Ella Patton, a registered nurse from the Division of Chronic Diseases, State Health Department of Texas, who holds a B. S. degree from Western Reserve University in Cleveland, Ohio, and a master's degree in public health from the University of Michigan.

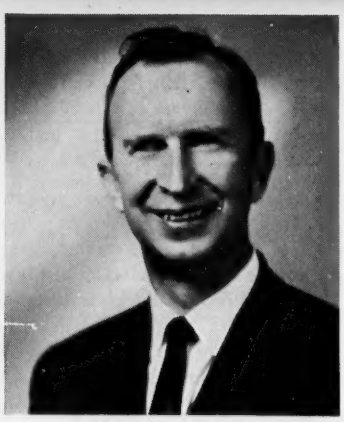
The first schedule under the contract has been met and upon completion of development of records in each of the 16 major categories, the records will be field tested in a representative group of nursing homes before final submission to the Department of Health, Education and Welfare and the Governing Council of the American Nursing Home Association.

One of the first steps incident to study was the tabulation of the results of a questionnaire which was sent to 4,000 member nursing homes of the American Nursing Home Association in the 48 states and nonmembers in the District of Columbia. The questionnaire covered the full gamut of nursing home records and the responses were as follows:

NURSING HOMES RECORDS QUESTIONNAIRE RESPONSES

By Regions and States

New England (152)	
Connecticut	29
Maine	13
Massachusetts	76
New Hampshire	16
Rhode Island	6
Vermont	12
Middle Atlantic (93)	
New Jersey	24
New York	42
Pennsylvania	27
East North Central (173)	
Illinois	50
Indiana	30
Michigan	40
Ohio	24
Wisconsin	29
West North Central (122)	
Iowa	25
Kansas	13
Minnesota	26
Missouri	25
Nebraska	19
North Dakota	7
South Dakota	7
Pacific (120)	
California	80
Oregon	10
Washington	30
South Atlantic (114)	
Delaware	1
District of Columbia	4
Florida	35
Georgia	22
Maryland	19
North Carolina	13
South Carolina	6
Virginia	9
West Virginia	5
East South Central (51)	
Alabama	12
Kentucky	15
Tennessee	15
Mississippi	9
West South Central (68)	
Arkansas	10
Louisiana	1
Oklahoma	16
Texas	41
Mountain (64)	
Arizona	8
Colorado	30
Idaho	6
Montana	5
Nevada	1
New Mexico	4
Utah	2
Wyoming	8



ELDRED THOMAS

The nursing home records practices as revealed by the study is indicated by the following:

NURSING HOME RECORDS PRACTICES
SUMMARY: 48 States, & District of Columbia

Kind of Record	Maintained	Not Maintained
I. PATIENT CARE		
Admission	955	2
Inventory	772	166
Physician Notes	937	8
Nursing Notes	921	21
Medication	882	50
Accident Report	583	249
Discharge	828	88
II. ADMINISTRATION		
Narcotics	682	247
Application Forms	607	266
Earning Record	901	24
Time Card	664	222
Medical Care Record	598	260
Termination	721	158
III. FINANCIAL		
Accountant	762	182
General Journal	544	36
Cash Receipts	581	35
Disbursements	554	33
Payroll Journal	599	19
General Ledger	555	45
Specialized Ledger (1)	197	73

(1) Responses to this section inadequate for comparable tabulation.

The tabulated responses indicate

a high degree of universality in records maintained by nursing homes.

Highest degree of standardization in purposes of records — not necessarily in kinds of forms — is in the area of Patient Care. This diminishes in the area of Administration and declines still further in regard to Financial records.

Patient Care: Admission, Physician's Notes, Nursing Notes, Medication and Discharge records are indicated to be standard in usage by virtually all responding nursing homes. In some instances, responses indicate records are kept in combination, rather than separately, e.g. Admission-Discharge, or Nursing Notes-Medication. Principal deviations from the pattern are records for Inventory of Personal Effects of Patients and Accident Reports.

Administration: While a majority of homes indicate use of most records listed on the questionnaire, the only record virtually universal in use is the Earning Record. Employee Application and Medical Care Records are least universal. (Medical Care was widely misconstrued by respondents as referring to patients and this should be taken into account.) A significant number of homes (27%) do not maintain narcotics records, although some replied this was not applicable for them.

Financial: An indicated 90 percent of homes retain services of accountants, of varying professional qualifications—from CPAs, to "bookkeepers" — at varying intervals of consultation or service. Responses to questions about specific financial records maintained are substantially less complete than under the two other sections. Appended comments of respondents suggest confusion regarding terms, latitude in systems, a high degree of individuality, and possibly some owner unfamiliarity with these records.

For the purpose of regional comparisons and standards, the table below shows U. S. averages and regional deviations on four questionnaire inquiries on which there were substantial variation from the basic pattern of universality.

NURSING HOME USE OF SELECTED RECORDS & ACCOUNTANTS U.S. AND REGIONAL AVERAGES

(% Indicates Respondents Replying Affirmatively)

REGION	TYPE OF RECORD			
	Inventory	Accidents	Narcotics	Accountant
U.S. Average	83%	70%	71%	90%
New England	84	80	90	86
Mid-Atlantic	80	82	97	89
South Atlantic	84	75	73	81
East North Central	85	66	74	81
West North Central	74	61	56	71
East South Central	91	58	46	74
West South Central	93	44	53	72
Mountain	77	82	67	75
Pacific	74	79	71	84

A noteworthy factor from the questionnaire responses is the influence of prescribed standards on uniformity of record-keeping. For example, admissions, records — as various operations noted — are commonly required by state laws or municipal ordinance and the incidence of use approaches 100%. Federal and state laws likewise account for near-100% use of earnings records. The important exception is on narcotics records, and deviation posing a question about the extent of unintentional non-compliance with Federal law.

The field testing and final reports are expected to be completed by August 1, and the results will be presented to the convention in Cleveland.

14 Occupational Therapy Assistants Graduate

By GEORGIA JAMESON

Montgomery County Tuberculosis and Heart Association
Kensington, Maryland

14 Occupational Therapy Assistants completed their three months training in Montgomery County Maryland on June 1, fully qualified for employment in Nursing Homes.

This is the first group to be trained by the pioneer, three-year project launched in Montgomery County last Fall. The programs' goal is to upgrade the care of nursing home patients without increasing costs. The O.T. Assistants will work under the supervision of a registered Occupational Therapist. Treatment programs will be planned with the patient's physician to maintain and improve physical and mental function through individual and group activities.

The training program is a joint effort on behalf of the Montgomery County Health Department, the Maryland Nursing Home Association, the District of Columbia, Maryland and American Occupational Therapy Associations, Montgomery County Board of Education and the Montgomery County Tuberculosis and Heart Association. It is financed by grants totalling $35,871; $29,871 from the Office of Vocational Rehabilitation and $6,000 from the Tuberculosis and Heart Association.

Applications are currently being accepted for the second class. Inquiries should be addressed to the Program Coordinator, Miss Virginia L. Caskey, OTR, Robert Peary High School, Rockville, Maryland.

ACCIDENTS HAPPEN BECAUSE . . .

By ALLEN PODELL
Administrator Brooklyn Hebrew Home and Hospital for the Aged
Brooklyn, N. Y.

One of the major problems facing the staffs of most homes and hospitals for the aged is the constant threat of injury to the geriatric patient through accident.

Aged patients are usually semi-invalids who are able to walk because of physical or mental disability. In many ways, they can be compared to the pediatric patient. Ambulation is not always possible; incontinence is a problem, and assistance in feeding, dressing and bathing are often necessary. In addition, geriatric patients often have difficulty communicating and are often senile.

In a study of accidents undertaken to determine what were the major causes of the accidents and what could be done to prevent them, the following were found to be the 20 major causes of patient acidents:

1. Lack of sure-footedness.
1. Impaired sight and hearing.
3. Receiving sedation at night.
4. Awakening suddenly and not recalling whereabouts.
5. Stumbling over objects and furniture that are out of place.
6. Slipping on floors made wet by incontinence and spillage.
7. Getting dizzy in the toilet.
8. Misjudging distances.
9. Trying to help one another unsuccessfully.
10. Using objects for support.
11. Climbing over bedside rails.
12. Rolling off chairs and out of bed.
13. Forgetting where they are.
14. Failing to wait for help.
15. Refusing manual assistance.
16. Refusing help when it is offered.
17. Having poor balance.
18. Being impatient.
19. Trying to get into or out of wheel chairs alone.
20. Ambulating, especially at night in the bathroom, without shoes.

Preventing these accidents calls for an intensive and continuing program of patient safety. Following are a few of the measures that would be important in such a program.

Two ways in which the patient accident rate can be reduced are by using better designed equipment and adapting standard furniture and equipment to the needs of the aged patient.

For patients with impaired sight and hearing, familiarity with surroundings is most important. Transferring these patients from one room to another causes many accidents. It is best not to transfer these patients unless it is absolutely necessary, because they lose their sense of direction in a new room. Also, with these patients the bed should be low enough so that a foot stool is not required. The room should have heavy, well balanced furniture. It is best to place these patients in rooms near the nurses' station and the bathroom.

Patients receiving sedation at night should have bed rails and a commode at the bedside.

Areas which house senile and incontinent patients should have good coverage by aides or orderlies who are briefed on the patients in their care. These areas should also have mobile equipment that can take care of the patients' needs at the bedside.

Patients who are known bedside rail climbers should have beds provided with half length rails, and the bed height should be adjusted so that foot contact is made with the floor when the patient is sitting on the bed.

Poor walkers and the impatient patients should have a well balanced mechanical walker available.

For the patients who have to spend a good part of their day in a chair and who have poor sitting balance, an adapted chair fashioned after a baby's high chair can be made. It should be a solid chair with broad base and side arms and have a slide-in tray and pommel to prevent the patient from sliding down.

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Calendar of Events

July 5-8, 1961 — Fifth National and International Convention of Senior Citizens' Clubs, Broadview Hotel, Wichita, Kansas.

July 12-15, 1961 — Catholic Hospital Association convention — Detroit, Michigan.

July 24-25, 1961 — AAHA Region III (Alabama, Florida, Georgia, Mississippi, North Carolina, South Carolina) Conference, Greystone Hotel, Gatlinburg, Tennessee.

Aug. 24-26, 1961 — Florida Nursing Home Association Convention, Colony Beach Club, Long Boat Key, Sarasota, Florida.

Aug. 29-31, 1961 — Tennessee Nursing Home Association Annual Convention, Patton Hotel, Chattanooga, Tennessee.

Sept. 25-28, 1961 — American Hospital Association convention — Atlantic City, N. J.

Sept. 28-30, 1961 — National Nursing Home Institute convention — Pick-Carter Hotel, Cleveland, Ohio.

Oct., 2-6, 1961 — American Nursing Home Association annual convention — Pick-Carter Hotel, Cleveland, Ohio.

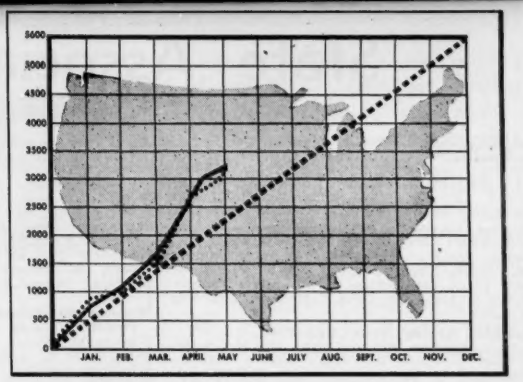
Oct., 16-17, 1961 — Licensed Nursing Home Association of New Jersey, Inc. Convention, Traymore Hotel, Atlantic City, N.J.

Oct., 24-25, 1961 — Iowa Nursing Home Association Convention, Hotel Kirkwood, Des Moines, Iowa.

Nov. 29-Dec. 2, 1961 — APWA's National Biennial Round Table Conference, Edgewater Beach Hotel, Chicago, Illionis.

The Scoreboard . . .

SOLID LINE—1961 Membership
DOTTED LINE—1960 Membership
BROKEN LINE—1961 Quota



Our congratulations and compliments to NEW MEXICO, LOUISIANA, OKLAHOMA WYOMING AND RHODE ISLAND . . . the five states that have either reached or surpassed 100% of their 1961 membership quotas.

Discuss with your State President . . . ways and means of getting new members. I'm sure the people of these states would be happy to share with you information as to the methods they used. I believe they will tell you a lot of hard work is involved in obtaining new members. The WORTHWHILE never COMES EASY. Hard work, door knocking, letter writing, telephone calls, with much patience and perseverance are required to get results.

Give this objective your best efforts—so that the August issue of our "Nursing Homes" journal can publish three or four times this number of states as having reached or surpassed 100 percent of the 1961 membership quota.

I. Nineteen states have reached or exceeded their 1960 total memberships:

Delaware	Mississippi	Rhode Island
Florida	Montana	South Dakota
Iowa	Nebraska	Utah
Kansas	Nevada	Vermont
Kentucky	New Mexico	Virginia
Louisiana	North Dakota	Wyoming
	Oklahoma	

II. Fifteen states have reached over 75 per cent of their 1961 quotas:

New Mexico	126%
Louisiana	122%
Oklahoma	113%
Wyoming	110%
Rhode Island	100%

* * *

Nebraska	94%
North Dakota	93%
Kansas	89%
Kentucky	88%
Delaware	88%
Florida	82%
Tennessee	80%
South Carolina	80%
California	77%
Washington	77%

A regional breakdown on percentage of quota attained through May 31, 1961:

Region	Quota '61	Membership '61	% of Quota
I	686*	278	40%
II	782	353	45%
III	608	420	69%
IV	632	327	51%
V	1125	601	53%
VI	392	300	76%
VII	496	298	60%
VIII	895*	667	74%
	5616	3244	57%

*All states in Region have not submitted quota.

	May 1960	May 1961	Total 1960	Quota 1961	% of Quota
ALABAMA	49	44	55	77	57%
ARIZONA	25	25	30	45	55%
ARKANSAS	33	33	39	54	61%
CALIFORNIA	406	483	592	624	77%
COLORADO	84	52	90	95	54%
CONNECTICUT	82	3	88	103	.02%
DELAWARE	14	15	14	17	88%
FLORIDA	80	103	87	125	82%
GEORGIA	63	69	73	100	69%
IDAHO	15	13	20	30	43%
ILLINOIS	150	149	183	250	59%
INDIANA	129	38	131	181	21%
IOWA	143	170	154	250	68%
KANSAS	50	58	52	65	89%
KENTUCKY	44	62	45	70	88%
LOUISIANA	17	33	17	27	122%
MAINE	40	36	40	60	60%
MARYLAND	65	61	69	100	61%
MASSACHUSETTS	220	117	284	400	29%
MICHIGAN	142	160	169	219	73%
MINNESOTA	49	74	109	300	24%
MISSISSIPPI	17	22	17	50	44%
MISSOURI	76	110	124	175	62%
MONTANA	19	25	21	50	50%
NEBRASKA	68	94	73	100	94%
NEVADA	2	2	2	19	10%
NEW HAMPSHIRE	58	52	59	not in	-0-
NEW JERSEY	60	56	84	165	33%
NEW MEXICO	15	19	15	15	126%
NEW YORK	79	66	175	210	31%
NORTH CAROLINA	55	57	68	100	57%
NORTH DAKOTA	13	14	14	15	93%
OHIO	59	50	72	122	40%
OKLAHOMA	47	113	65	100	113%
OREGON	32	19	34	44	43%
PENNSYLVANIA	88	101	110	200	50%
RHODE ISLAND	21	27	25	27	100%
SOUTH CAROLINA	18	20	21	25	80%
SOUTH DAKOTA	18	35	33	47	74%
TENNESSEE	116	105	119	131	80%
TEXAS	75	100	107	300	33%
UTAH	8	22	15	not in	-0-
VERMONT	29	43	41	96	44%
VIRGINIA	42	54	44	90	60%
WASHINGTON	104	103	111	133	77%
WEST VIRGINIA	22	17	30	40	42%
WISCONSIN	109	98	122	150	65%
WYOMING	22	22	22	20	110%
TOTAL MEMBERS	3,172	3,244	3,964	5,616	57%

State Associations Directory

Alabama Nursing Homes Association
President: Garland L. Rollins, P.O. Box 305, Falkville. Secretary: Mrs. J. H. Kelly, P.O. Box 88, Haleyville. Treasurer: Robert V. Santini, Route 12, Box 158, Birmingham. A.N.H.A. Governing Council Member: Garland L. Rollins.

Arizona Association of Nursing Homes
President: Mrs. Roy Williams, 1916 N. 32nd Street, Phoenix. Secretary: Ione A Dockstader, 6825 North Sixteenth Street, Phoenix. Treasurer: Mrs. Frank Maus, 9110, N. 7th Street Phoenix. A.N.H.A. Governing Council Member: Mrs. Roy Williams.

Arkansas Nursing Home Association
President: Mrs. Mason Comer, 604 N. 4th St., Lonoke. Secretary: Mrs. Jackie Kilgore, Caraway. Treasurer: Jo Gribble, 953 David O'Dodd Rd., Little Rock. A.N.H.A. Governing Council Member: Mrs. Mason Comer.

California Association of Nursing Homes, Sanitariums, Rest Homes & Homes for the Aged, Inc.
President: Marion Gellmann, 924 Balboa St., San Francisco. Secretary: Mrs. Fern Robinson, 3201 Fernside Boulevard, Alameda. Treasurer: Birre Gipe, 541 North Fulton, Fresno. A.N.H.A. Governing Council Member: Mrs. Gellmann.

Colorado Nursing Home Association
President: H. Virgil Davis, 1427 Gaylord, Denver. Secretary: Dorothy Cording, Route 1, Eldorado Springs Road, Boulder. Treasurer: Vesta Bowden, 1455 Beeler Street, Aurora. A.N.H.A. Governing Council Member: H. Virgil Davis.

The Connecticut Chronic and Convalescent Hospital Association, Inc.
President: Theodore E. Hawkins, 1768 Whitney Ave., New Haven. Secretary: Vera Arterburn. 267 Union Ave., West Haven. Treasurer: Leander Lavigne, 157 Hillside Ave., Waterbury. A,N.H.A. Governing Council Member: Mrs. Robert Baird, North Star Route, New Milford.

Delaware Association of Nursing Homes
President: Alice Ulmer, 160 Winston Avenue, Elmhurst, Wilmington 4. Secretary: Blanche Williams, Clarksville. Treasurer: Paul J. Turek, 1506 North Broom Street, Wilmington 6. A.N.H.A. Governing Council Member: Alice Ulmer.

Florida Nursing Home Association
President: Ernest Ripley, 1711 6th Ave., S., Lake Worth. Secretary: Ann Tompkins, 1006 West Main St., Leesburg. Treasurer: Frank Cuyler. 504 3rd Ave., South, Lake Worth. A.N.H.A. Governing Council Member: Ernest Ripley.

The Georgia Association of Nursing Homes and Homes for the Aged
President: Thomas E. Anthony, 2725 Vineville Avenue, Macon. Secretary: William M. Crane. 663 North Milledge Street, Athens. Treasurer: Louis Newmark, 260 14th Street, N. W., Atlanta 13. A.N.H.A. Governing Council Member: Thomas E. Anthony.

Idaho Nursing Home Association, Inc.
President: Virgil Harter, Payette, Idaho. Secretary-Treasurer: Mrs. Virgil Harter, Payette, Idaho. Governing Council: Virgil Harter.

Illinois Nursing Home Association
President: Margaret Setzekorn, 1300 Broadway, Mt. Vernon. Secretary: Jeannette Kramer, 417 North Kenilworth, Oak Park. Treasurer: Helen Nelson, 205 North Main, Saybrook. A.N.H.A. Governing Council Member: Margaret Setzekorn.

Indiana Association of Licensed Nursing Homes
President: Margaret L. Nickols, 812 Riverside Avenue, Muncie. Secretary: Marjorie M. Fordyce. 321 North Morgan Street, Rushville. Treasurer: Emory H. Vollmer, 2630 North College Avenue. Indianapolis. A.N.H.A. Governing Council Member: Marjorie Pearsey, 114 East Fifth Street. Rushville.

Iowa Nursing Home Association
President: Charles B. Shindler, 1211 Pleasant Street, Des Moines. Secretary: C. B. Verdoorn Ashton. Treasurer: W. S. Bauman, 222 North 18th Street, Clarinda. A.N.H.A. Governing Council Member: Charles B. Shindler.

Kansas Nursing Home Association, Inc.
President: L. V. Biffer, Jr., P. O. Box 812. Wichita. Secretary. Viola Wagner, 301 West First. Washington. Treasurer: Robert E. Truitt. 525 East Second Street. Tonganoxie. A.N.H.A. Governing Council Member: Louisa Joplin, Box 632 McLouth.

Kentucky Association of Nursing Homes
President: Mrs. Ann Ralph, 105 Lyndon Lane, Lyndon. Secretary: Mrs. Bernice Sisk, 419 North Seminary, Madisonville. Treasurer: Jack Bousman, 1460 South 2nd St., Louisville 8. A.N.H.A. Governing Council Member: Ira O. Wallace, New Castle Sanitarium, New Castle.

Louisiana Association of Licensed Nursing Homes, Inc.
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President: Kenneth Robinson, 284 Brunswick Avenue, Gardiner. Secretary: Alzada Simmons, Western Avenue, Winthrop. Treasurer: Roy Meister, 25 Court Street, Belfast. A.N.H.A. Governing Council Member: Kenneth Robinson.

Maryland Nursing Home Association, Inc.
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Massachusetts Federation of Nursing Homes
President; Joseph H. Furlong, Jr., Frost Rd., Washington, Mass. Secretary: Sydney Nathans, M.D., 890 St. James Ave., Springfield, Mass. Treasurer: Joseph J. Alessandroni, 91 Summer St., Waltham, Mass. A.N.H.A. Governing Council Member: Frithiof B. Carlson, 44 Old Upton Rd., Grafton, Mass.

Michigan Nursing Home Association
President: Ila Arthur, 515 Lyon St., N. E., Grand Rapids. Secretary: Dr Robert Cotton, 9230 Ann Arbor, Rt. No. 2, Grass Lake. Treasurer: Emmett Calhoun, 1404 W. Territorial Rd., Battle Creek. A.N.H.A. Governing Council Member: Ila Arthur.

The Minnesota Nursing Home Association
President: Sidney S. Shields, 209 Security Building, University at Raymond, St. Paul 14. Secretary: Naime Wessin, 725 Fremont Avenue, North, Minneapolis. Treasurer: Raymond C. Olson, 400 10th Avenue, N. W., Austin. A.N.H.A. Governing Council Member: Karl T. Spellum, Lester Prairie.

Mississippi Nursing Home Association
President: J. W. Pigford, Highway 39 North, Meridian. Secretary: Mary W. Majure, Route 5, Highway 11, Meridian. Treasurer: Mrs. R. S. Compere, 865 North Street, Jackson. A.N.H.A. Governing Council Member: J. W. Pigford.

Missouri Nursing Home Association
President: Walter McCarty, 3621 Warwick, Kansas City 11. Secretary: Kathryn Lindeman, 3537 Main Street, Kansas City. Treasurer: Etta Kelly, 4123 Independence Avenue, Kansas City. A.N.H.A. Governing Council Member: Walter McCarty.

Montana Nursing Home Association
President: Mary Sande, Box 156, Box Elder. Secretary: Nellie Cornelius, 208 South 35th St., Billings. Treasurer: Joe Ronchetto, 444 W. Broadway, Butte. A.N.H.A. Governing Council Member: Mary Sande, Box 156, Box Elder.

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Nevada Nursing Home Association:
President: Leandro D. Tomaso, 1015 Spanish Springs Rd., Reno. Secretary-Treasurer: Beverly Tomaso, 1015 Spanish Springs Rd., Reno. A. N. H. A. Governing Council Member: Leandro D. Tomaso.

The New Hampshire Association Licensed Nursing Homes
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Licensed Nursing Homes Association of New Jersey, Inc.
President: George E. Conley, 82 North Main Street, Cranbury. Secretary: Leonard A. Coyle, 562 Lafayette Avenue, West Trenton. Treasurer: Jesse Wallace, 304 Teaneck Road, Teaneck. A.N.H.A. Governing Council Member: George E. Conley.

New Mexico Association of Nursing Homes, Inc.
President: Kathryn Vaskov, Rt. 1, Box 96-A, Las Cruces. Secretary-Treasurer: Olga Vaskov, Rt. 1. Box 96-A, Las Cruces. A.N.H.A. Governing Council Member: Kathryn Vaskov.

New York State Nursing Home Association, Inc.
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North Carolina Assn. of Nursing Homes and Homes for Aged, Inc.
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Rhode Island Association of Nursing Homes
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President: Elmer C. Kocovsky, M.D., 6217 West Lloyd Street, Wauwatosa. Secretary: Mary Bernikowicz, 6014 18th Ave., Kenosha. Treasurer: Eileen Wagner, 1804 N. 10th St., Monroe. A.N.H.A. Governing Council Member: Elmer C. Kocovsky, M.D.

Wyoming Association of Nursing Homes
President: Clara Jokimaki, State Park, Thermopolis. Secretary: Wilma Bigner. West C & 14 Ave., Torrington. Treasurer: Beulah Bushmaker, 244 East Works, Sheridan. A.N.H.A. Governing Council Member: Clara Jokimaki.

If You Ask Me

QUESTIONS AND ANSWERS ABOUT NURSING HOMES

By BRUCE UNDERWOOD, M.D.

Q.— The food service department in my nursing home is equipped with old equipment and the layout is not efficient. Where can I get information on good layouts and equipment?
A.— First it is suggested that you contact your State or local agency that is responsible for licensing nursing homes and discuss your plans with them. This will eliminate the possibility of expending a large sum of money and ending up with a non-approvable food service. The licensure agency may be able to provide some consultation on equipment layout, also equipment manufacturers as well as professional consultants in this field can provide valuable assistance.

Before buying food service equipment you should be aware of the seal of approval of the National Sanitation Foundation. This non-profit organization publishes standards on food service equipment and issues seals of approval to equipment manufacturers who sell equipment meeting its standards. Detailed information can be obtained by writing to the National Sanitation Foundation, Ann Arbor, Michigan.

Q.—Are there some special qualities I should look for when I hire nursing personnel for my nursing home?
A.— The answer to your question is "yes." First and foremost they must like old people. They should have a sympathetic kindliness and thoughtfulness, without pity. They should have a sense of humor, that quality that serves so well in every endeavor in our lives. Nursing personnel need patience and tact because elderly people sometimes become talkative and may seem unreasonable at times. They also may appear "fixed" in their ways, and therefore nurses should be flexible so that needless adherance to regulations or procedures do not make the patients irritable and unhappy.

Older people are frequently lonely and have many fears and worries. Therefore, nurses caring for them need to be "good listeners," with friendliness, warmth and genuine interest in them as individuals. Worries and fears can often be allayed by careful explanations and reassurance or by just letting the patient talk and express his fears. The need for explanations and reassurance is particularly important during the first few weeks in a nursing home. Change is difficult for everyone but it becomes much more difficult to adjust to new environments and new routines as we grow older.

The need for privacy should not be overlooked. The elderly patient may be painfully conscious of his physical infirmities that have caused him to lose out in competition with relatives and friends. If he has been forced by illness to accept a situation entirely different from that to which he is accustomed, he may be ever so grateful for even the smallest indications of respect for his dignity. A screen carefully placed, a door carefully closed, or careful attention to keeping him covered for assurance of privacy during a bath are but a few of the little things that can be done to make his illness less painful.

An attitude of optimism is essential in caring for elderly people. Sometimes, considering their many ailments, the impression is that the situation is hopeless. However, this is seldom true. Many old people adjust to their disabilities and are greatly benefited by good medical and nursing care. There are very few who cannot be improved by supportive medical treatment and by thoughtful and kind nursing.

Lastly, it must be remembered that the ability to do for one's self is very important to human happiness. It is often easier and quicker for nurses to bathe the patients, dress them, put on their shoes and wait upon them in many ways; rather than allow them to help themselves. It is good planning to arrange the nursing care schedule so that nursing personnel will have time to help and encourage patients to do as much as they can for themselves and be spared the feeling of inadequacy when they are hurried.

THANK YOU

This will be my last column. I deeply appreciate the many kindnesses which have been shown me as Editor. It has been a real privilege to have had this opportunity of service and I shall continue to treasure the friendships and pleasant contacts that have resulted.

In closing, I wish to say:

Thank you to the officers and members of the American Nursing Home Association, and to others who have been readers of the column. Especially do I thank all who submitted questions and comments concerning the column. The cooperation of the staff in the A.N.H.A. Headquarters Office was outstanding and much appreciated.

I extend to my successor best wishes and am looking forward to being a reader of the column and on occasion being one who submits a question.

Thank you.

Bruce Underwood, M.D., Editor
"If You Ask Me"

Dr. Felix J. Underwood
Miss. State Board of Health
Jackson, Miss.

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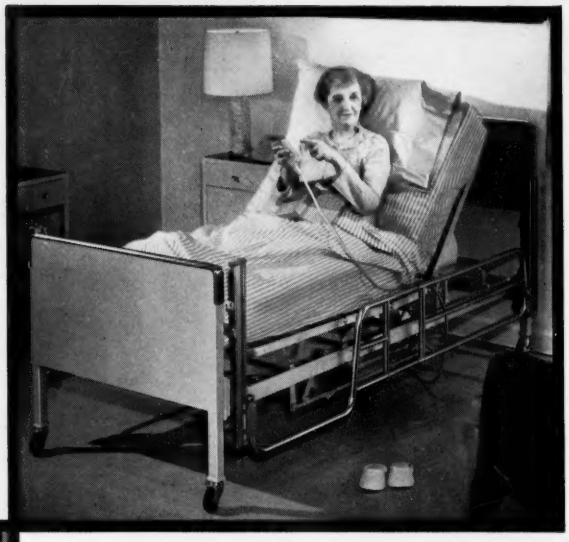

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